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REVIEW OF ORPHANS AND VULNERABLE CHILDREN (OVC) IN HIV/AIDS GRANTS AWARDED BY THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA (ROUNDS 1–7)

AUGUST 2010

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EXECUTIVE SUMMARY

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is a major source of funding in the response to HIV, including programs targeted to orphans and vulnerable children (OVC). In June 2010, the Global Fund reported that programs funded by it have provided 4.9 million basic care and support services to orphans and vulnerable children. Today, over 163 million children are living as orphans; of these, 17.5 million have lost one or both parents to AIDS (USG, 2009). In the face of the growing OVC population, current global, regional, national, and community responses to OVC, while commendable, are insufficient to meet the needs of all orphaned and vulnerable children, including those infected or affected by HIV and AIDS. In its role in responding to AIDS, tuberculosis, and malaria, the GFATM supports a country-driven response that must ensure that OVC are appropriately prioritized and served by GFATM grants in-country.

The USAID | Health Policy Initiative, Task Order 1, conducted this comprehensive desk review, followed by a pilot country study (Pfleiderer and O. Kantai, 2010), to better understand the extent of OVC inclusion in GFATM processes. The desk review that resulted in this report reviewed documents for 261 HIV grants retrieved from the grant database on the Global Fund's web site. It did not include other kinds of Global Fund grants, including health systems strengthening (HSS) grants. Specifically, the review examined the extent to which approved country proposals, grant agreements, amended grant agreements, grant performance reports, grant score cards, disbursement requests, and, where relevant, Rolling Continuation Channel (RCC) proposals included OVC-related content. The Global Fund grants reviewed include a broad group of children defined as orphans based on country-level definitions.

The desk review found that 116 of 261 approved Global Fund HIV/AIDS proposals in Rounds 1 through 7 included OVC objectives and that sub-Saharan Africa accounted for 68 of the 116 approved proposals (59 percent) with OVC goals or objectives.

However, not all OVC objectives included in the proposals were reflected in the respective grant agreements. In total, 77 of the 261 grants had grant agreements with OVC objectives, including 64 with OVC objectives in both the original proposals and corresponding grant agreements. Thirteen grants did not specify OVC objectives in their proposals but included them in the grant agreements. Most grants that included OVC in the grant agreements were not limited to OVC but included OVC among several other objectives as part of a national HIV/AIDS response.

The review further examined the 77 grants with OVC specified in the corresponding grant agreements. The research team classified 18 of the 77 grants as "OVC focused"—that is, the grants defined OVC objectives; outlined strategies, interventions, and activities to achieve the OVC objectives; and reported on progress in achieving the objectives. The majority of the 18 OVC-focused grants targeted children living with HIV and, to a lesser extent, children affected by HIV. Such grants dealt with HIV prevention, schooling, and livelihood training interventions.

The review also searched grant documents for any mention of OVC. The few grants with OVC-specific budget information provided only limited information. Grants with OVC objectives often included OVC under broad HIV activities in the national response instead of funding for OVC-specific activities. Such grants often outlined broad prevention, treatment, and impact mitigation activities.

The review identified trends in grant activities; for example, several of the 18 OVC-focused grants funded family programming rather than interventions for individual children. In addition, some grants stressed social and community networks in OVC programming.

Based on the findings of the review, the report's recommendations suggest that country-level stakeholders, including Country Coordinating Mechanisms (CCMs), international agencies, and the Global Fund need to consider the following key issues:

- Address OVC data constraints, including increasing funding to support data collection that will contribute to proposals based on evidence and coverage levels;
- Strengthen the demand-driven process at country level with regional support to improve data collection related to OVC;
- Establish and/or more effectively use a country-level, operational definition of OVC and integrate it into all related country-level documentation for improved identification, implementation, reporting, and tracking of OVC programming;
- Promote impact mitigation for children affected by HIV and AIDS as a key population throughout the Global Fund grant processes;
- Include OVC champions on CCMs and provide advocacy and programming training for OVC stakeholders;
- Build the capacity of local stakeholders to cost activities to mitigate impact for children and base OVC funding allocations on tested costing and impact models;
- Strengthen the monitoring and evaluation of OVC-specific initiatives by developing robust indicators, reporting, and participatory processes that account for beneficiary inputs; and
- Review inclusion of highly vulnerable children in all Global Fund grants, including HIV, tuberculosis, malaria, and HSS grants, and expand the review to assess and understand impact mitigation of these diseases and the role of HSS on children made vulnerable by the three diseases.

A better understanding of how orphans and vulnerable children are included in or excluded from Global Fund processes can help address barriers and opportunities for appropriate prioritization and improved services for children. While this report is one of the first to comprehensively address OVC within the purview of Global Fund grants, it is not an evaluation. This report stands as an introductory analysis that aims to generate discussion and a body of work to improve benefits to OVC from the Global Fund.

ABBREVIATIONS

AGA	Amended Grant Agreement
AIDS	acquired immune deficiency syndrome
CCM	Country Coordinating Mechanism
CRC	UN Convention on the Rights of the Child
CSO	civil society organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPR	grant performance report
HIV	human immunodeficiency virus
HSS	health systems strengthening
HVC	highly vulnerable children
JLICA	Joint Learning Initiative on Children and HIV/AIDS
LAC	Latin America and the Caribbean
LFA	local fund agent
M&E	monitoring and evaluation
MENA	Middle East and North Africa
NA	not available
NGO	nongovernmental organization
NPA	National Plan of Action (for Orphans and Vulnerable Children)
OGAC	Office of the Global AIDS Coordinator
OVC	orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PL109-95	United States Public Law 109-95
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PR	principal recipient
PRSP	Poverty Reduction Strategy Paper
RCC	Rolling Continuation Channel
SR	sub-recipient
TB	tuberculosis
TRP	Technical Review Panel
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

INTRODUCTION

The HIV epidemic has revealed a broad range of vulnerabilities faced by children and their families. Such vulnerabilities are especially apparent in sub-Saharan Africa, which accounts for the highest HIV prevalence in the world combined with structural risk factors, including high poverty rates, low life expectancy, high infant and child mortality, and low education levels, particularly among women and girls (World Bank, 2007).[1]

The latest report on orphans and vulnerable children (OVC) by the U.S. Government (USG) and partners estimated that, in 2008, 163 million children (age 0–17 years) across the globe were orphans (referring to loss of one or both parents to all causes) and that 17.5 million of these children lost one or both parents to AIDS (USG, 2009). The global figure of 17.5 million orphans as a consequence of AIDS represents an increase from the 2007 estimate of 15 million AIDS-related orphans (UNAIDS, 2008). Moreover, children under age 15 living with HIV totaled 2 million in 2007, with 1.8 million of these children residing in sub-Saharan Africa (UNAIDS, 2008).

The varied way in which vulnerability is measured across countries means that precise counts of the world's total number of vulnerable children do not exist, yet approximations related to specific types of vulnerability attest to the magnitude of the problem: 428 million children age 0–17 years live in extreme poverty, 150 million girls have experienced sexual abuse, 2 million children live in institutional care, and 218 million children engage in various forms of exploitative labor (USG, 2009). The conditions faced by these children are exacerbated by deeply entrenched poverty, poor access to healthcare, increased vulnerability to diseases that include HIV, and other material and non-material deprivation (Richter et al., 2004).

Many countries rely on the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to finance their national HIV/AIDS programs and the required health infrastructure. Currently, the Global Fund provides approximately 20 percent of international funding to fight HIV, 63 percent of international funding to fight tuberculosis (TB), and 60 percent of international funding to fight malaria (UNAIDS, 2009; GFATM, 2010).[2] The USG has provided 25.6 percent of the contributions to the Global Fund, with Congress mandating a limit of 33 percent.

The Global Fund is a public-private partnership established in 2002 to mobilize and intensify the international response to three global epidemics and strengthen health systems to help achieve the Millennium Development Goals. From its founding through December 2009, the Global Fund Board approved proposals totaling US$19.2 billion and disbursed US$10 billion for HIV, TB, and malaria control efforts. To maximize impact, every donated dollar funds in-country programs. The Global Fund maintains no country offices and its operating expenses are almost entirely covered by the interest earned on the Trustee account at the World Bank.

According to the *2010 Global Fund Innovation and Impact Report*, GFATM-funded programs provided 4.9 million basic care and support services to orphans and other vulnerable children. While the reported number of child beneficiaries is sizable, international and national groups agree that more must be done to improve the types, scale, and effectiveness of services provided to reach millions more orphans and other vulnerable children around the world (e.g., UNICEF et al., 2008; UNAIDS, 2009).

[1] Data from various sources are presented in Tables 5 and 6.
[2] UNAIDS. 2009. "Call for Fully Funded Global Fund to Fight AIDS, Tuberculosis, and Malaria." Available online at http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090331_GF.asp.

PURPOSE AND OBJECTIVES

This paper analyzes Global Fund support for OVC activities as the basis for developing recommendations for strengthening OVC initiatives. The paper's specific objectives are to

1. Examine the extent to which OVC content is included in Global Fund proposals, grant agreements, and disbursements;
2. Identify potential factors that facilitate or hinder the inclusion of OVC in Global Fund grants; and
3. Recommend ways to strengthen OVC inclusion in Global Fund proposals, grant agreements, and disbursements.

While this report is one of the first to comprehensively address OVC within the purview of Global Fund grants, it is not an evaluation. This report stands as an introductory analysis that aims to generate discussion and a body of work to improve benefits to OVC from the Global Fund.

CONTEXTUAL FRAMEWORK FOR THE DESK REVIEW

Policies, programs, and interventions may be analyzed by focusing on their content and objectives, the context in which they were formulated and approved, the main actors involved, and the processes that led to their formulation, approval, and implementation (Walt and Gilson, 1994). Stover and Johnston (1999) analyzed the process of comprehensive national HIV policy formulation in selected African countries by identifying the main actors and steps taken to address the epidemic. Hardee et al. (2004) described the need to understand different components of the "policy circle" in order to assess how a problem is addressed. The authors call for examining the people and institutions that make decisions that affect the problem as well as those with a stake in the problem and its solution, the processes involved in policy or program formulation and approval, the resulting policy decision, its "price tag" or related budget, the program and its associated strategies and interventions for policy implementation, and program performance.

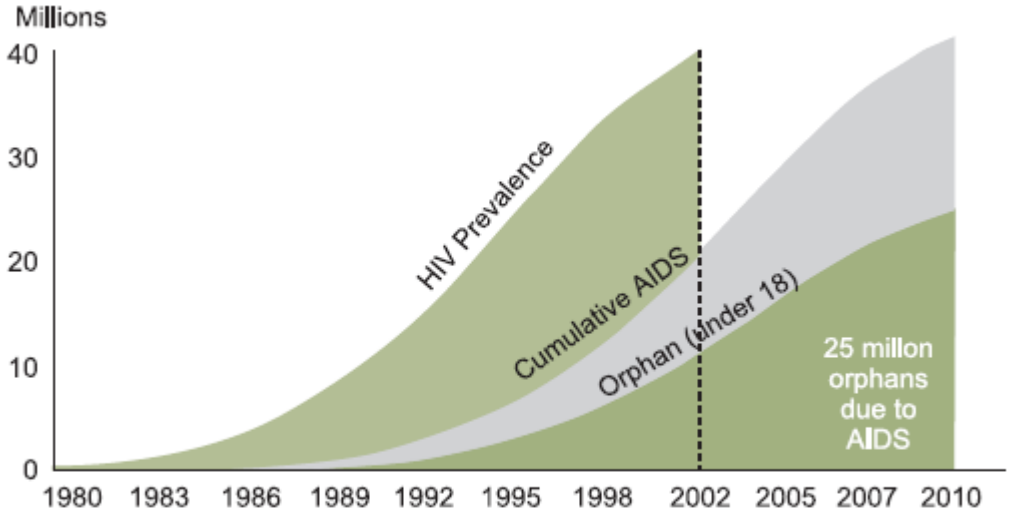
Frameworks such as those mentioned above identify key elements to be considered in analyzing the extent and nature of the OVC focus in Global Fund grants. For example, to analyze the "people" in this review, the research team assessed the level of OVC representation on the Country Coordinating Mechanism (CCM) in particular. To analyze the "price tag," the team reviewed budget reports and line items allocated for OVC-related activities. The team also analyzed programming by using OVC-specific searches and reviewing proposals, grant agreements, and grant performance reports. However, the grant information on the Global Fund web site is not presented in a standardized format that permits assessment of the grants in keeping with the frameworks described above. Hence, the research team identified milestones in the OVC focus (see Annex 2) and related the trends in OVC inclusion in Global Fund HIV/AIDS grants to the milestones, such as policies that marked a shift in the OVC response at global, regional, national, and community levels.

The HIV and AIDS Epidemic

The HIV epidemic has been depicted as a succession of three waves: HIV, AIDS, and adult deaths with concomitant social impact by the orphaning of children (see Figure 1). The first wave is that of rising HIV prevalence, followed by a second wave of AIDS-related illnesses and death. The third wave illustrates the children left behind—either orphaned or made vulnerable by HIV and AIDS. In their foreword to the Joint Learning Initiative on Children and HIV/AIDS (JLICA) report (2009), Bell and Binagwaho

described the HIV epidemic as a long-wave phenomenon with complex, unpredictable ramifications occurring into the future at uncertain intervals.

Figure 1. Epidemic Curves: HIV, AIDS, Orphans[3]



Source : *UNAIDS/UNICEF, 2003, adapted from Whiteside, A. and C. Sunter, 2000.*

To some extent, countries have implemented their HIV responses in waves or stages. Stover and Johnston's (1999) study of the response to HIV in Africa characterized the first-stage country response as medical-oriented, following the approach taken to address the first recognized cases of AIDS in the United States during the early 1980s. The second stage involved a public health response as the number of AIDS-related deaths increased. In the third stage, international organizations later called for a multisectoral response to deal with the broader social and economic implications of HIV and AIDS. It is clear that the push for comprehensive policies emerged only when the epidemic became so severe that a large portion of the population was affected, spurring advocacy efforts (1) to convince decision makers of the urgent need for a policy response (Stover and Johnston, 1999) and (2) to establish HIV prevention, testing, treatment, care, and support programs.

In consideration of the tendency of affected countries to respond to the HIV epidemic in phases, it is not surprising that recent AIDS epidemic updates (UNAIDS, 2009) note significant progress in achieving targets for treatment and the prevention of mother-to-child transmission (PMTCT), although universal access to these services and coverage remains a challenge in many countries. Yet, the HIV response demands a broader response, including prevention (beyond PMTCT) and more holistic care and support programs that meet the needs of OVC (UNAIDS, 2008).

Key Issues

The Health Policy Initiative identified seven issues regarding the global response to OVC within the current research focus. These issues provided the contextual background for the review.

[3] The graph is reproduced from the framework document prepared by UNAIDS, UNICEF, and the Global Partners Forum (2004).

1. Definition of OVC and Vulnerable Children

The definitional issue revolves around the concept of OVC and how it should be operationalized. The shift from "AIDS orphans" to orphans and children made vulnerable by HIV and AIDS over time is commendable considering that many children directly affected by HIV and AIDS, especially in sub-Saharan Africa, also often face a broader set of vulnerability factors, including poverty, the need to care for sick parents or other family members, food insecurity, armed conflict, harmful child labor practices, gender-related barriers and vulnerabilities, and inadequate access to basic health and education services. Despite today's more refined estimates of children living with HIV and children orphaned by AIDS, the definition of highly vulnerable children (HVC) (which encompasses OVC) also differs according to country and local context. While experts agree that the number of vulnerable children greatly surpasses estimates of children orphaned by AIDS (UNAIDS, UNICEF et al., 2004), the determination of which and how many children are vulnerable to HIV or are orphans as a consequence of HIV is largely contextual. Careful country-level analysis is required to determine which children are most vulnerable based on local factors, including HIV prevalence, poverty, sociocultural and political environments, and the existence of basic services.

2. Shift from Family- to Individual-centered Approach and back to Family-Centered/Community Network Approach

The rapid increase in funding for OVC services and the accompanying pressure to report high numbers of children reached with such services led to a focus on individual children. JLICA (2009) criticized the shift to the individual child and recommended a family-centered response that builds on the strengths of existing local social networks and community organizations.[4] Families and communities are the front-line providers, often the only providers of OVC care and support in some parts of developing countries facing high HIV prevalence and resulting mortality. The family-community response builds on many developing countries' cultural norms and structures. "Families" is broadly taken to mean "social groups connected by kinship, marriage, adoption, or choice" (JLICA, 2009).

3. Slow OVC Response

The milestones (Annex 2) illustrate the significant amount of time that elapsed before countries with a high HIV prevalence or large number of children orphaned by AIDS started to address OVC. As early as 1991, UNICEF drew attention to orphans through the International Conference on AIDS Orphans, followed by a collaborative effort of USAID, UNICEF, and UNAIDS during the rest of the 1990s to estimate the magnitude of the problem. In 2001, 189 UN member-states signed the UNGASS Declaration of Commitment whose targets included orphans—girls and boys affected and infected by HIV and AIDS. International fora reaffirmed the targets in succeeding years. However, it was only after 2003 that sub-Saharan countries severely affected by HIV developed national plans of action (NPAs) for children affected by HIV/AIDS. While some countries were attempting to pass laws addressing vulnerable children, several sub-Saharan countries took approximately another four years to develop their OVC NPAs (Engle, 2008). International organizations helped jump start the planning efforts, but the most highly affected countries needed financial resources and technical guidance on how to plan to address OVC.

According to the 2008 UNAIDS Report (2008), of the 33 countries with generalized epidemics that provided data, 91 percent signified the existence of a policy or strategy addressing the needs of OVC (see 2008 UNGASS Country Progress Reports). The 15 highest-prevalence HIV countries have now formulated NPAs and assembled data on the number of OVC reached with support programs.[5] China and India—with 17 and 25 million orphans, respectively, from all causes (UNICEF et al., 2009)—have

[4] See also Schenk (2008).
[5] The country reports were confirmed by in-country NGOs (2008 UNGASS Country Progress Reports).

instituted programs to reach more OVC, likely in recognition of their particularly high orphan-related burdens. The report, cautions, however, that, despite the formulation of national plans, it could not gauge the degree to which countries had budgeted for and implemented the plans. In addition, monitoring and evaluation of OVC programs continues to be absent or weak (USG, 2009). Moreover, most OVC planning and programming has occurred in high-prevalence countries.

4. Varied OVC Characteristics and Needs

Significant assistance to OVC has focused on food and schooling, including tuition, uniforms, and fees (JLICA, 2008; Sherr, 2008). However, OVC are not a homogeneous group. In particular, the needs of very young children in vulnerable circumstances vary significantly from those of school-going ages and differences should be recognized between girls and boys. Yet, government investment for the very young is limited, except for child health and immunization and preventing mother-to-child transmission of HIV (Engle, 2008). Clearly, the developmental requirements of OVC in the pre- and post-school age groups demand attention. In addition, gender is a major consideration; young girls and boys have varying biological, social, cultural, and emotional needs and vulnerabilities that may be further heightened by their orphan status or vulnerable household environments.

5. Implied Gaps in Services and Resources to Reach All OVC

The large gaps between the number of OVC needing and receiving care and support persist. Programs funded by the President's Emergency Plan for AIDS Relief (PEPFAR) across countries reported reaching 2.7 million children by September 2008—up from 1.2 million in 2005. The *2010 Global Fund Innovation and Impact Report* states that Global Fund-financed programs provided 4.9 million basic care and support services to orphans and other vulnerable children. It has also taken time to articulate "reach" in Global Fund data and how services relate to numbers of children serviced with not only basic, but comprehensive services. However, the figures represent only a fraction of the millions of OVC across the globe (JLICA, 2009; USG, 2009). AIDS orphans alone numbered as many as 17.5 million in 2007 (UNICEF et al., Fourth Stocktaking Report 2009). Precise estimates of children vulnerable to HIV and AIDS are not available but, by all implications, are likely to be staggering and to have been exacerbated by the current global economic crisis (USG, 2009). Moreover, the gap in numbers served by programs should be viewed vis-à-vis the gaps in services needed by OVC. Less attention and fewer resources have been directed to impact mitigation programs than to HIV treatment, PMTCT, and other HIV services (UNAIDS, 2008), although even within these areas, services for children have lagged behind those provided to adults. The lack of attention to orphans and other children made vulnerable by HIV has been compared to the lack of attention to women—a silent epidemic made silent by vulnerable children's limited access to basic rights and services in parts of the world with the least resources (Sherr, 2008).

6. OVC Participation in Decisionmaking

OVC stakeholders, including beneficiaries, should be involved in OVC policymaking and programming decisions that affect their lives and communities. Policymakers, planners, and managers of OVC services at different levels—from national to local governments and nongovernmental partners—traditionally make policy and program decisions. The leadership of high-level officials and managers can help ensure an enabling environment for OVC services and counter stigma and discrimination against children and families living with or affected by HIV. However, OVC and their families must participate in decisions that affect them. Their participation, and that of community groups supporting OVC, can identify needs as well as barriers to service access and help ensure the effective use of resources and program sustainability. They can also serve as powerful advocates and champions of OVC, including on CCMs.

7. Need for Well-Coordinated Responses

International assessments are critical of "silo" approaches. Rather than targeting individual orphans and creating institutional structures to replace families, donors and OVC advocates now emphasize family-

centered approaches that address the health, nutrition, training, and psychosocial needs not only of OVC but also of parents and caregivers who must often care for several vulnerable children. The silo approach also refers to the tendency of individual ministries to focus only on their own "turf" instead of coordinating interventions with those of other ministries or organizations, thereby ignoring crucial opportunities to foster broader impacts and long-term sustainability. It is important to determine if a country is committed to efforts to link or integrate health, education, economic, and psychosocial services provided to OVC and their families.

Summary of Key Issues

Interventions for OVC care and support have to be well coordinated, even integrated where possible, to maximize the potential benefits for OVC. Responses also need to be holistic and family focused. However, in view of the varied characteristics of OVC and types of services that they require, the resources needed to meet the needs of OVC are in short supply. Many affected families likely have several children with different developmental needs. The participation of OVC and their families in determining needed services is important, but little evidence suggests that participation is taking place. Social and community networks can play key roles in responding to the needs of OVC as can regional networks, but they need training and guidance as well as resources and coordination to ensure that they reach and advocate for OVC effectively and efficiently.

DATA AND METHODOLOGY

As discussed, many countries rely on the Global Fund to finance their national HIV/AIDS programs, including programs for the care and support of OVC. Given the U.S. Government's contributions to the Global Fund and its keen interest in strengthening OVC programs, USAID commissioned the Health Policy Initiative to examine the extent and nature of OVC content in Global Fund HIV proposals, grant agreements, and related progress reports.

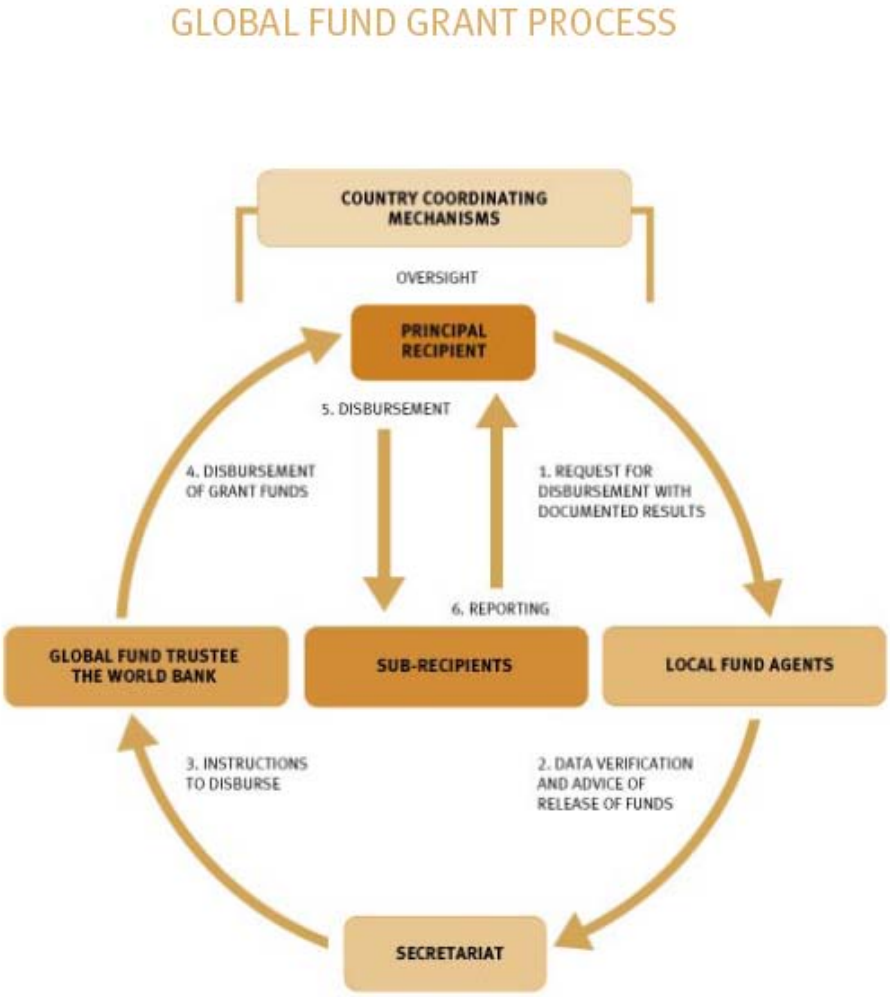
Data Source

This report presents findings and analyses based on a desk review of information retrieved from the Global Fund's database of approved grants. The Grants Portfolio section of the Global Fund's website provides a wealth of information on approved grants, including readily available information by country and funding round as follows: proposals with accompanying goals, objectives, strategies, and activities; information on principal recipients; CCM members and affiliations; grant agreements; start dates (and end dates where relevant); budgets; indicators and targets; grant performance reports; disbursement requests; and requests for continued funding. The database also provides updates and reports of achieved targets and results.

The review focused on the following aspects of all HIV/AIDS grants approved by the Global Fund from Round 1 through Round 7 (2002–2007) (see Annex 3 for a glossary of terms):

- OVC stakeholder and USAID representation in the CCM
- Principal recipients (PRs)
- Inclusion of OVC in proposals
- OVC-specific goals or objectives in proposals
- Inclusion of OVC in grant agreements
- OVC-specific goals or objectives in grant agreements
- Strategies to meet OVC objectives in proposals and grant agreements
- Inclusion of OVC in amended grant agreements
- Inclusion of OVC in grant performance reports and/or grant score cards

- Inclusion of OVC in disbursement requests
- Inclusion of OVC in Rolling Continuation Channel (RCC) proposals
- Definition of OVC in grants
- Differences in OVC content among proposals, grant agreements, and grant performance reports
- OVC budget-related information in proposals, grant agreements, disbursement requests, grant performance reports, and requests for continued funding
- OVC gender-related information in grant documents
- OVC age-set–related information in grant documents



Source: The Global Fund Grant Making Process (2009), available at: www.theglobalfund.org/documents/publications/brochures/whoweare/TGFBrochure_GlobalFundGrantMakingProcess.pdf.

The desk review of HIV/AIDS grants began in May 2008 and concluded in August 2009. In consideration of the number of recipient countries, grants, and related documents, four two-person teams were assigned to a particular Global Fund Unit (Africa, Asia, Eastern Europe, Latin America and the Caribbean, Middle East and North Africa) and then to regional teams within each unit. Within each team, one member conducted an initial review of documents and key search terms, entering information based on the above criteria that was then reviewed by a second team member. Team members entered a code or descriptive information into an Excel spreadsheet that was then combined into a searchable Access database for tabulation and table generation.

The search parameters for the review originally included the following keywords: OVC, orphan, orphans, highly vulnerable children (or HVC), child/children, girl(s), boy(s), infant(s), baby, babies, mother(s), father(s), youth, and their equivalents in French and Spanish, where appropriate. However, given the breadth of information, time, labor, overlap with non-focus groups such as adults, and conflict inherent in documenting aspects of programming related to a broad keyword search, the research team decided, upon consultation with the OVC Technical Working Group (TWG), to narrow the search parameters to mitigation-specific interventions. As a result, keywords used in the focused search and related data inputs included orphan, orphans, and OVC in English; *orphelin*, *orphelins*, and OEV in French; and *huérfano*, *huérfanos*, and *huérfanos y niños vulnerables* in Spanish. Accordingly, team members excluded largely preventive interventions, such as HIV-related peer education for all adolescents. With the significant descriptive data and comments entered into Excel, the team carried out further data processing and categorization by using Access software. The second technical team member reviewed the same documents reviewed by the first team member to counter-check codes and data entries and then edited the latter as needed. The main authors of the report then combined and analyzed the tabulated data and focused on OVC-specific information and activities.

The focused keyword search resulted in the exclusion of grants primarily focusing on other groups of highly vulnerable children in need or at-risk but not identified as affected by AIDS, such as grants to Iran that focused on youth and North Sudan that focused on street children. With a broad keyword search, such grants would have been part of the present analysis such that a clear, operational definition of OVC across all rounds and countries would become too broad for reasonably addressing the population of interest. Further, initially operating within a broader keyword search included age-sets as an additional challenge: children, adolescents, youth, and adults with overlapping ages across the entire set of grants.

Data Constraints and Limitations

The study could not comprehensively investigate all factors that potentially affected the content of country-specific HIV proposals and grants. Moreover, the Global Fund counted over 900 signed grants by the end of 2009; the desk review assessed 261 HIV grants. Global Fund grants vary greatly in content because of their context-specific and dynamic nature. Multiple actors are involved in proposal development, grant implementation, and M&E. Moreover, varied country-level contexts influence actors and processes that, in turn, influence the HIV issues that eventually become a proposal's or grant's focus. As a desk review, this study could not capture many nuances of program implementation, which often are not reflected in available written reports. For our framework, we reference international events, reviews, policies, and programs to provide the broad context that could potentially have shaped country initiatives funded by the Global Fund (see Annex 2).

The review was limited to information available on the Global Fund's web site as of August 2009 when the research team completed its review. Available information across countries varied in terms of content and completeness. For example, grant agreements were not available for some grants. Certain grants, especially those approved in earlier rounds, lacked information on their status (e.g., completed, active, or suspended). The dynamic nature of the reporting includes constant posting and re-posting updates of reports to the Global Fund web site itself. There is also more information to be found in other kinds of grants, in particular, HSS grants, not included in this review. Further, CCMs are dynamic in nature, having different members join and cycle off CCMs over time. This review used a particular window in time for the review, but could not capture the full process of the country-level programming and all of the dynamics of changing data over time and how that is represented by the data source used. Internal reporting at country level was also not included in this review; however, this reporting does have more detailed information regarding key reporting areas included in this review. Tracking related to sub-

recipient activities and funding flows also was not included or accessible. The report discusses other data constraints in the context of specific issues.

Key Definitions Used in the Review

Countries and donors use different definitions of OVC based on local context and priorities and, where possible, data. Historically, with the emergence of information on the HIV epidemic's drivers and impacts, stakeholders expanded their definitions of vulnerability to include poverty, hunger, gender, armed conflict, and harmful child labor practices. International donors and advocacy groups also pointed to the high-risk status of children in communities that are extremely poor and devastated by HIV and AIDS as well as children living with mental and physical disabilities. The national policies and plans of many African countries now term as vulnerable those children living in households providing foster care, children living in communities affected by HIV, and children (and their families) living in extremely poor communities (Sherr, 2008).

National and international studies and documents commonly use the abbreviation OVC yet largely cite data on children who are orphaned by AIDS and HIV-positive children, although certain countries' categories of vulnerability define vulnerable children in many different ways. The definition of OVC used by the Health Policy Initiative team approximates PEPFAR's definition which defines orphans as children under 18 who have lost either a mother or father (Office of the Global AIDS Coordinator, 2006)[6] but excludes PEPFAR's reference to children who are discriminated against, stigmatized, or marginalized. While the research team recognizes that such children are indeed vulnerable, projects submitted to the Global Fund generally provide limited information on stigma-related indicators as applied to the child population. Moreover, orphans and children who are living with or affected by HIV and AIDS most likely experience stigma or discrimination and thus are counted to some extent under the categories used in the desk review.

The desk review defines OVC care and support services primarily as the provision of social and/or economic services that include legal aid and services to secure birth registration, protection of rights, educational assistance (such as tuition and uniforms), food and nutrition support, emotional and psychological counseling, shelter, clothing, day care, temporary relief for the care of sick persons in the household, development of kids' or youth clubs, monetary support (such as cash transfers), health education, and linkage or referral to health clinics and medical care. Care and support services also encompass support for caregivers and communities, assistance for home-based care, home visits, and training for caregivers and workers involved in social protection or economic support for OVC and their families/guardians. The desk review did not address HIV/AIDS grants focused solely on HIV prevention, testing, and/or treatment if they did not include keywords listed in the modified search parameters. Among the activities excluded from the analysis, for example, are efforts to assist at-risk populations that might include youth (e.g., street children, drug users, and so forth), PMTCT services, or medical treatment for people living with HIV (PLHIV) who might include young children.

The Health Policy Initiative's review did not intend to define the term OVC. Rather, the team searched for inclusion of the key words listed above, in Global Fund reporting and documentation. In each country, the definition is country- and context-specific, but the team looked for a common word or key term to provide consistency across the 261 grants and related 2,000+ grant documents.

[6] Our definition is also similar to the World Bank's (2005) categories of children affected by HIV/AIDS.

FINDINGS AND ANALYSIS

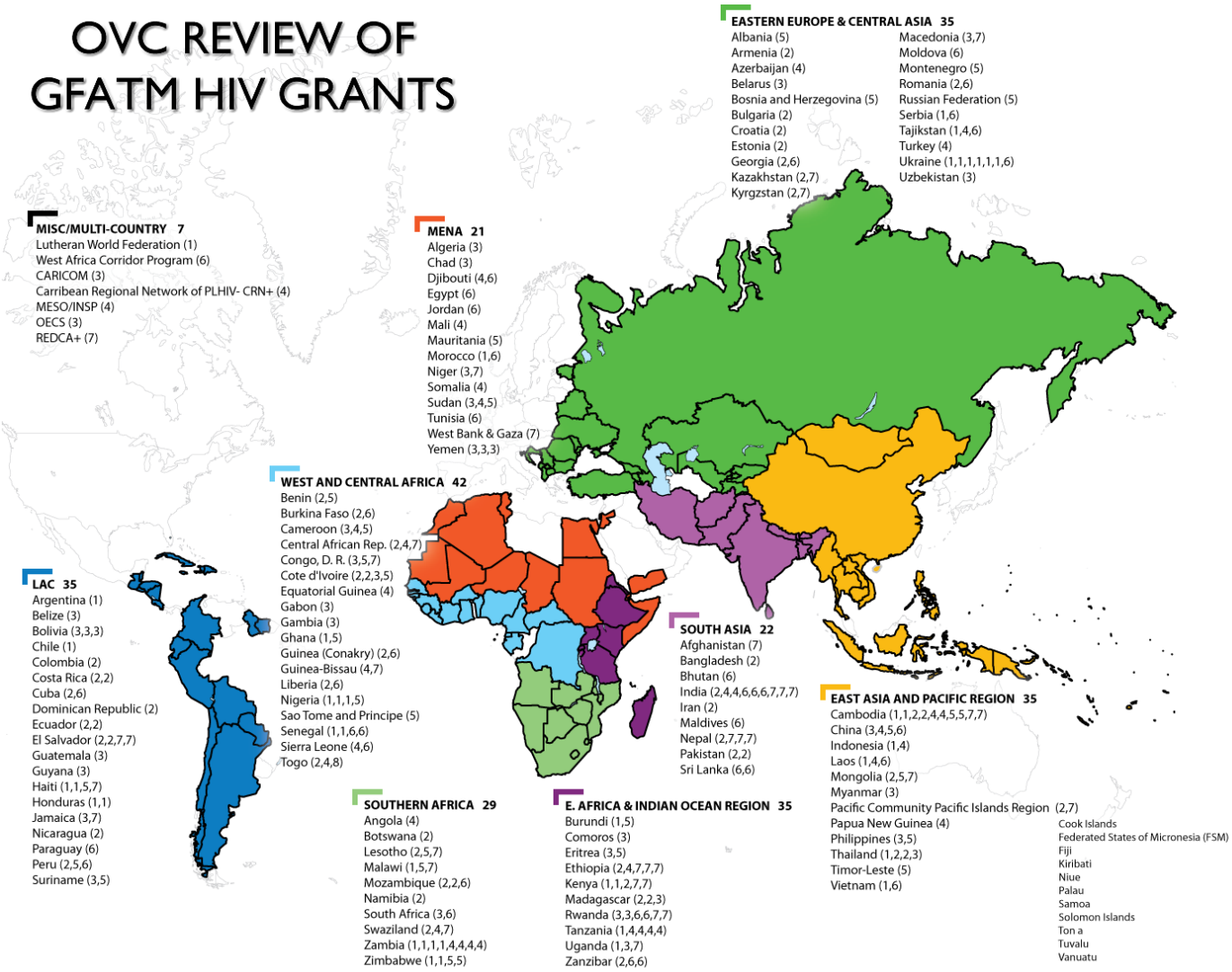
This main section of the report presents findings and analysis on the OVC focus and content of approved Global Fund HIV/AIDS grants. It starts with an overview of approved Global Fund HIV/AIDS grants, followed by an in-depth discussion of key findings organized as follows: the extent of inclusion of OVC objectives in proposal goals and/or objectives, with reference to specific funding year and rounds; OVC representation in CCMs; and the extent of inclusion of OVC objectives in final grant agreements. The discussion then focuses on the OVC content of the few HIV/AIDS grants with a pronounced OVC focus.

Overview of Global Fund HIV/AIDS Grants

For information purposes, the funding rounds of the Global Fund[7] were as follows:

- Round 1–approved by the Global Fund Board in April 2002
- Round 2–approved in January 2003
- Round 3–November 2003
- Round 4–June 2004
- Round 5–September 2005
- Round 6–November 2006
- Round 7–November 2007
- Round 8–November 2008
- Round 9–November 2009

[7] The source of the information is http://www.theglobalfund.org/en/fundingdecisions/?lang=en, accessed January 12, 2010.



The desk review focuses on data from HIV/AIDS grants in Rounds 1 through 7. The Global Fund approved 261 HIV/AIDS grants from 122 countries in the seven rounds. Of those 122 countries, 38 (31%) included OVC representatives in their CCM (as per the CCM member listing found on the Global Fund web site under each awarded grant). Table 1 presents the regional distributions of OVC representatives in CCMs.

Table 1. Regional Distribution of OVC Representatives in CCMs

	East Africa and Indian Ocean	South-ern Africa	West and Central Africa	South Asia	East Asia and Pacific	Eastern Europe and Central Asia	Middle East and North Africa (MENA)	Latin American and the Caribbean (LAC)
Total countries awarded HIV grants in the region	10	10	19	9	12	22	14	25
Total countries with OVC representatives (total = 38)	2	3	14	2	1	0	4	12

The low proportion of CCMs with OVC representatives may partly reflect the assumption that individuals representing youth or student associations, education or social welfare ministries, PLHIV groups, or even faith-based organizations adequately represent OVC concerns. Examples of stakeholders classified by the research team as specifically addressing OVC are agencies/organizations such as Ministry of Child Welfare, nongovernmental organizations (NGOs) involved in the legal or social protection of children, or organizations recognized globally for OVC programming. Even so, it is unclear which organizations serve as advocates for OVC.

Table 2 summarizes the key information regarding all Global Fund HIV/AIDS grants in Rounds 1 through 7. Sixty-six of the 122 recipient countries' (54%) Global Fund proposals set forth OVC goals or objectives. Of the 261 total HIV/AIDS grants, 116 (44%) of the proposals outlined OVC objectives. The 116 proposals are discussed more fully in the next subsection. Further, 77 (30%) included OVC in grant agreements.

Table 2 also shows that 25 out of 261 grants involved amended grant agreements (AGA) with revised OVC objectives. Of the 25, 20 AGAs (80%) outlined new or further refined OVC objectives and/or goals while the remaining 5 no longer mentioned OVC, even if earlier grant agreements included OVC objectives or indicators. In terms of grant performance reports (GPR), 111 of the 261 approved grants' (42%) GPRs mentioned OVC, but some OVC entries were in the narrative sections of the GPRs and not related to objectives or indicators. Seventy-seven of the 111 GPRs (69%) specified OVC indicators, including 45 grants that did not mention OVC in the grant agreements. Only 56 of all 261 HIV grants provided information on budgets with OVC indicators, interventions, or activities.

A mere 35 out of 261 approved grants included gender-related information on OVC, but most gender information or references were limited to the proposals. Even more noticeable was the limited number of grants with age-specific definitions or references to OVC. Twenty-seven of the 261 approved HIV/AIDS grants (10%) provided information on the age-sets of the OVC of interest, with birth to 17 years the most common age specification.

Table 2. Global Fund and OVC Summaries

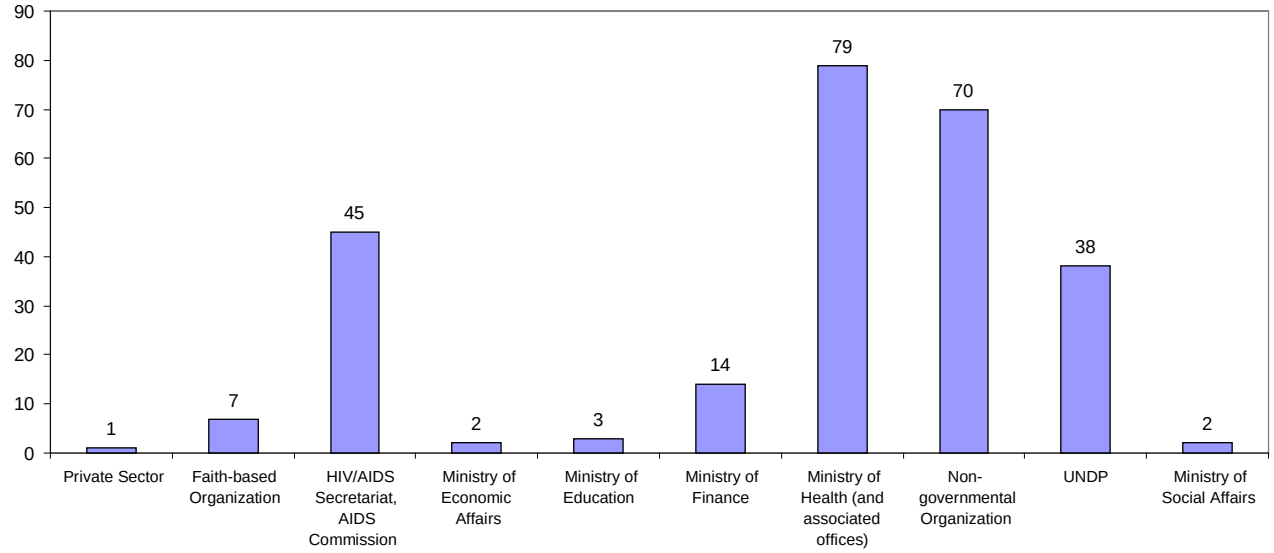
Summary Information on Countries Approved for HIV/AIDS Grants
122 countries were approved for 261 HIV/AIDS grants
38 (31%) included OVC representatives in the CCM
66 (54%) included OVC in proposal goals and/or objectives
Summary Information on All HIV/AIDS Grants
261 approved HIV/AIDS grants from Rounds 1 through 7 included in desk review
116 (44%) included OVC in proposal goals and/or objectives
77 (30%) included OVC in grant agreements
38 (15%) included OVC in disbursement requests
9 (3%) had RCC proposals with OVC
Amended Grant Agreement Information
25 out of 261 grants (10%) had AGAs with changes regarding OVC
20 of the 25 (80%) included new or further refined goals/objectives related to OVC
5 of the 25 (20%) did not mention OVC

Grant Performance Report Information
111 out of 261 grants (43%) had GPRs mentioning OVC
66 of the 111 grants (60%) with GPRs mentioning OVC had OVC content in grant agreement
53 of the 66 grants (80%) had OVC targets* in GPRs
45 out of 261 grants (17%) had OVC in GPRs but no mention of OVC in grant agreements
24 of the 45 grants (53%) had OVC targets* in GPRs
77 (53 + 24) total GPRs had OVC targets*
Gender-Related Information on OVC
35 of 261 grants (13%) included gender-related Information
31 of the 35 grants (88%) included OVC information in proposals, 2 in GPRs, 1 in RCC proposal, and 1 in grant agreement
Budget-Related Information on OVC
56 of the 261 grants (21%) included OVC budget-related information
46 of the 56 grants (82%) included OVC budget information in proposals, 5 in grant agreements, 1 in GPR, and 1 in AGA
Age-Specific Reference to or Related Information on OVC
27 of the 261 grants (10%) included some definition of or age reference to OVC
29 (11%) included age-set–related information
25 (9%) included age-specific information in proposals, 3 in GPRs, and 1 in all documents

*Most countries with OVC targets in the GPRs used indicators that were expressed in numbers (e.g. number of HIV-positive children provided with care and support services).

Figure 2 summarizes the PRs of the HIV/AIDS grants in Rounds 1 through 7. Ministries of Health (77), NGOs (68), and National AIDS Secretariats or Councils (45) dominate the list. Aside from health ministries, other government ministries served as PRs. PRs from outside government included local and international NGOs and the United Nations Development Program (UNDP), which often functions as a PR if a suitable in-country organization cannot be identified. No PR was an OVC-specific organization. Based on the documents available online at the time of the review, the team could not determine if OVC organizations were among sub-recipients (SR).

Figure 2. Principal Recipients of Global Fund HIV/AIDS Grants



Detailed Findings on Grants with OVC Components

Definition of OVC

A major constraint in the review involved the basic question about how HIV/AIDS grants defined OVC or specified the population encompassed by "orphans and vulnerable children." While countries are encouraged to define OVC according to their situation and environment, 234 of the 261 approved HIV proposals (90%) did not define OVC. Nearly all of the remaining 10 percent of grants provided a definition or specified an OVC reference group that primarily constituted orphans under age 18 per the definition of the UN Convention on the Rights of the Child (CRC). The Democratic Republic of the Congo (DRC) Round 7 grant is one of the few grants that provided a detailed definition of OVC by applying a set of vulnerability criteria for OVC: loss of one or both parents, living in a family where one parent is living with HIV, non-schooled children, homeless children, at least three children in a family (page 104 of the proposal does not explain the family size criterion but suggests that large family size may be a vulnerability issue). Ethiopia, while not defining OVC, stated in its proposal that support for OVC will target the most needy groups by refining the selection criteria used by the grant's implementing partners.

Inclusion of OVC Goals/Objectives in HIV/AIDS Proposals

As stated, 116 of the 261 approved HIV/AIDS grants (44%) set forth OVC objectives. Table 3 presents a regional breakdown of the total number of approved HIV/AIDS proposals that specified OVC goals/objectives. The 116 approved proposals include those focused solely on OVC objectives as well as those whose OVC objectives were among several other objectives, including prevention, testing, and treatment. To the extent that information was available in the Global Fund's database, the research team noted grants that merely checked an OVC-related indicator among several other indicators.

The regions with the highest percentages of proposals with OVC objectives were East Africa and the Indian Ocean (71%), West and Central Africa (61%), Southern Africa (59%), South Asia (50%), East Asia and the Pacific (46%), Middle East and North Africa (MENA) (43%), and multi-country America (40%). The lowest percentages were Latin America and the Caribbean (LAC) (23%) and Eastern Europe

and Central Asia (6%). However, it should be noted that some regions had a larger number of grants awarded, for example, in Southern Africa as opposed to the MENA region.

Sub-Saharan Africa accounted for the most proposals with OVC objectives or goals: 68 of the 116 proposals (58%) were from East Africa and the Indian Ocean (25 or 22%), West and Central Africa (26 or 22%) and Southern Africa (17 or 15%). East Asia and the Pacific and South Asia together (27 or 24%) accounted for the second largest number of proposals with OVC objectives.

Table 3. Global Fund HIV/AIDS Grants and Number with OVC Objectives in Original Proposals, by Region

Region	Number of Approved HIV/AIDS Grants (column 1)	Number of Grants with OVC Objectives (column 2)	Percentage of Regional Grants with OVC Objectives (column 3 = column 2/column1)	Percentage of All Grants with OVC Objectives (column 2/116)*
East Africa and Indian Ocean	35	25	71	22
West and Central Africa	43	26	61	22
Southern Africa	29	17	59	15
East Asia and the Pacific	35	16	46	14
South Asia	22	11	50	10
Eastern Europe and Central Asia	35	2	6	2
LAC	40	10	25	9
MENA	21	9	43	8
Lutheran World Federation[8]	1	0	0	0
Total (global)	261	116	42	100*

* Total exceeds 100 percent because of rounding.

It is not surprising that sub-Saharan Africa accounts for the largest *number* of grants with OVC goals or objectives. The earliest and most recent estimates of children orphaned by AIDS (USAID et al., 1997; UNICEF and UNAIDS, 2004; UNICEF et al., 2009; USG, 2009) indicated that countries in sub-Saharan Africa have the largest proportions of children orphaned by AIDS among all orphans due to all causes. The estimates, which span several years, also indicate that the number of children orphaned by AIDS in that region has been increasing rapidly primarily because of particularly high adult HIV prevalence rates (e.g., exceeding 20% in some countries across the southern part of the continent). By contrast, adult HIV prevalence across almost all Asian countries is estimated at less than 1 percent. However, given the large populations of China, India, and Indonesia, Asia had the largest overall number of AIDS orphans according to the earliest estimates (USAID, 1997). The most recent international estimates for Asian

[8] The Lutheran World Federation is a Geneva-based international NGO. It was granted one multi-country grant to raise the awareness of religious leaders regarding HIV. It worked in partnership and with the permission of CCMs for implementation of their $700,000, three-year grant. For more information see: http://www.theglobalfund.org/grantdocuments/1WRLH_306_62_summary.pdf.

countries and other countries with HIV prevalence under 1 percent provide numbers for orphans due to all causes, with no statistics on children orphaned by AIDS.

Funding Rounds and Approval Dates of Proposals with OVC Goals/Objectives

Figure 3 presents approved proposals with OVC goals/objectives by funding round; Figure 4 specifies the number of approved Global Fund proposals with OVC goals/objectives by year of approval.

Figure 3. Proposals with OVC Objectives by Round

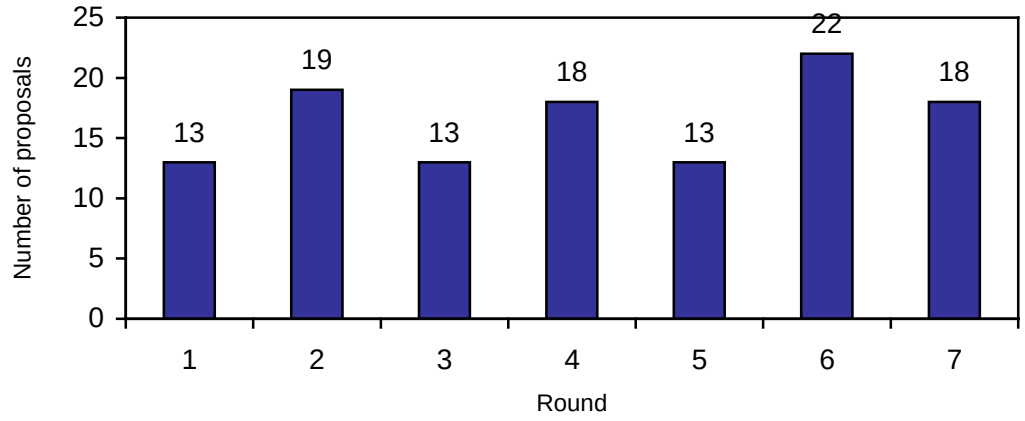
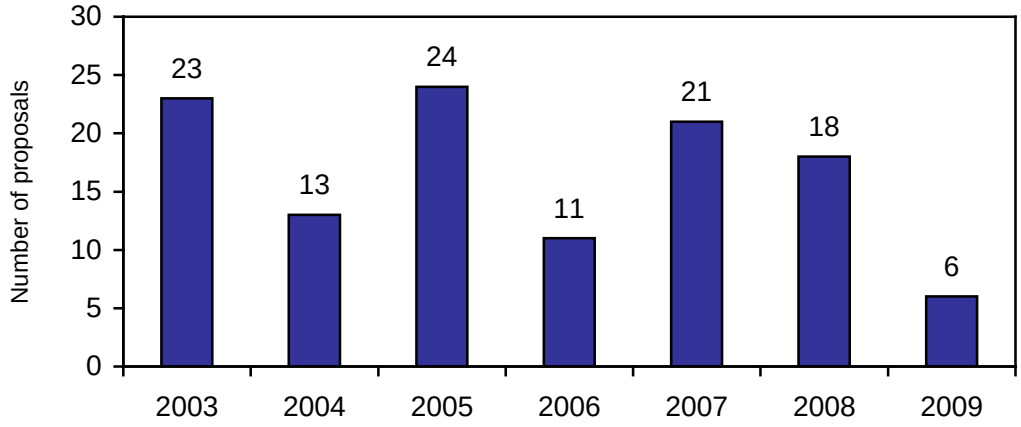


Figure 4. Proposals with OVC Objectives by Start Date*



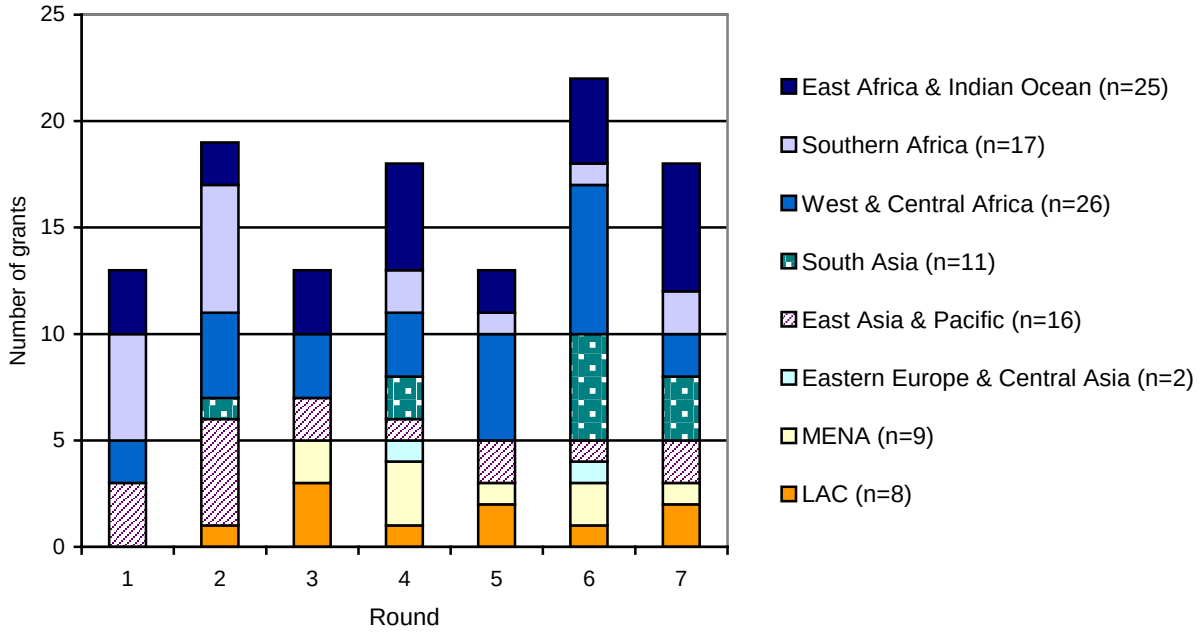
*Includes six proposals with no information on start dates; the year was approximated based on available start dates.

While the Global Fund approved some but not all Round 1 HIV/AIDS grants in 2002 (the fund's first full year of operation), it did not approve any proposals with OVC objectives until 2003, when it funded 23 proposals as noted by the start date on the grant agreements.

As stated, sub-Saharan Africa and Asia accounted for the large share of approved proposals with OVC objectives and goals. Figure 5 presents the regions of and rounds for the approved proposals with OVC objectives. In Rounds 1, 2, 4, and 5, most approved proposals with OVC objectives came from sub-Saharan Africa. Rounds 1 and 2 accounted for several proposals with OVC objectives from Southern

African countries. In Round 1, East Asia and the Pacific was the only region outside Africa for which the Global Fund approved proposals with OVC objectives. In Round 2, South Asia and LAC joined East Asia and the Pacific in approvals for proposals with OVC objectives. In Round 3, MENA and LAC saw the approval of proposals with OVC objectives; MENA continued to see approvals in Rounds 4 through 7. Eastern Europe secured approvals for proposals with OVC objectives in Rounds 4 and 6.

Figure 5. Approved Proposals with OVC Objectives by Region and Round*



* See Annex I for complete breakdown of numbers used for this figure.

Figure 5 further reveals that, starting with Round 3, only a few Southern African proposals with OVC objectives received approval, perhaps in part because several countries from the region received grants in Rounds 1 and 2. On the other hand, East Africa and the Indian Ocean saw increasing numbers of approved proposals in Rounds 3 and 4, a "lull" in Round 5, and an increase again in Rounds 6 and 7. West and Central Africa registered the greatest number of approved proposals with OVC objectives in Rounds 5 and 6. Further analysis, however, is needed to determine if there are logical trends according to rounds.

OVC Objectives in Approved HIV/AIDS Proposals and Country-Specific Data on Adult HIV Prevalence and Children Orphaned by AIDS

Based on the findings above regarding funding rounds, the research team identified which countries submitted proposals with OVC objectives. The team also categorized countries based on adult HIV prevalence rates (UNICEF et al., 2009; USG, 2009) to tabulate data on OVC. Tables 4 and 5 present data on countries by region, the inclusion of OVC objectives in approved HIV/AIDS proposals, adult HIV prevalence, number of children orphaned by AIDS, and the number of orphans due to all causes.

Table 4 focuses on countries that evidenced a 1 percent or higher adult HIV prevalence and received HIV/AIDS grants; nearly all such countries are located in sub-Saharan Africa (except Estonia, Papua New Guinea, and Russia). In view of HIV prevalence rates, all countries in Table 4 account for children

orphaned by AIDS and orphans due to all causes, thereby allowing approximations of proportions of children orphaned by AIDS.

Table 5 provides information on countries that have less than 1 percent adult HIV prevalence and have received Global Fund HIV/AIDS grants. Most such countries lack available estimates of children orphaned by AIDS, although data are available on orphans due to all causes. The only exceptions are the African countries of Comoros, Madagascar, and São Tomé and Príncipe, which provided estimates of the number of children orphaned by AIDS. Because of the nature of the HIV epidemics and, often, the stigmatization and criminalization of associated risk behaviors, children—even in low prevalence countries—may still be highly vulnerable.

As shown in Tables 4 and 5, nearly all sub-Saharan African countries with an HIV prevalence of 1 percent or higher *and* data on children orphaned by AIDS received approved HIV/AIDS proposals that set forth OVC objectives. Only Zimbabwe did not include OVC objectives in its approved HIV/AIDS proposals. Estonia, Papua New Guinea, and Sudan are the remaining countries with HIV prevalence rates of 1 percent or higher without OVC objectives in an approved proposal. On the other hand, countries with prevalence under 1 percent were less likely to receive approval for proposals that spelled out OVC objectives, except in the case of countries with a particularly large number of orphans due to all causes (e.g., India and China). Another exception is São Tomé and Príncipe, which received approval for a grant that included OVC objectives even though it had no estimates of HIV prevalence or number of orphans.

Table 4. Statistics for Countries with HIV Prevalence above 1 Percent

Country	Round in Which OVC Were First Included in Approved Proposal Objectives	Estimated Adult HIV Prevalence (%) (age 15 to 49 years), 2007	Children Who Lost One or Both Parents, All Causes, 2007	Children Who Lost One or Both Parents to AIDS, 2007	Children orphaned by AIDS as Percentage of All Orphans
Angola	4	2.1	1,200,000	50,000	4%
Belize	(None)	2.1	5,500	n.a.	n.a.
Benin	2	1.2	340,000	29,000	9%
Botswana	2	23.9	130,000	95,000	73%
Burkina Faso	6	1.6	690,000	100,000	14%
Burundi	5	2	600,000	120,000	20%
Cameroon	3	5.1	1,100,000	300,000	27%
Central African Republic	4	6.3	280,000	72,000	26%
Chad	3	3.5	540,000	85,000	16%
Congo, Republic of	(None)	3.5	210,000	69,000	33%
Congo, Democratic Republic of the	3	1.3	4,500,000	n.a.	n.a.
Côte d'Ivoire	2 (part a)	3.9	1,200,000	420,000	35%
Djibouti	4	3.1	42,000	5,200	12%
Dominican Republic	(None)	1.1	170,000	n.a.	n.a.

Country	Round in Which OVC Were First Included in Approved Proposal Objectives	Estimated Adult HIV Prevalence (%) (age 15 to 49 years), 2007	Children Who Lost One or Both Parents, All Causes, 2007	Children Who Lost One or Both Parents to AIDS, 2007	Children orphaned by AIDS as Percentage of All Orphans
Equatorial Guinea	(None)	3.4	32,000	4,800	15%
Eritrea	3	1.3	280,000	18,000	6%
Estonia	(None)	1.3	n.a.	n.a.	n.a.
Ethiopia	2	2.1	5,000,000	650,000	13%
Gabon	3	5.9	67,000	18,000	27%
Gambia	3	0.9	48,000	2,700	6%
Ghana	1	1.9	1,100,000	160,000	15%
Guinea	2	1.6	380,000	25,000	7%
Guinea-Bissau	7	1.8	110,000	5,900	5%
Guyana	(None)	2.5	23,000	n.a.	n.a.
Haiti	5	2.2	380,000	n.a.	n.a.
Jamaica	(None)	1.6	53,000	n.a.	n.a.
Kenya	1	7.8	2,500,000	n.a.	n.a.
Lesotho	7	23.2	160,000	110,000	69%
Liberia	6	1.7	270,000	15,000	6%
Malawi	1	11.9	1,100,000	550,000	50%
Mali	4	1.5	550,000	44,000	8%
Mozambique	2	12.5	1,400,000	400,000	29%
Namibia	2	15.3	110,000	66,000	60%
Nigeria	5	3.1	9,700,000	1,200,000	12%
Papua New Guinea	(None)	1.5	330,000	n.a.	n.a.
Russian Federation	(None)	1.1	4,000,000	n.a.	n.a.
Rwanda	3	2.8	860,000	220,000	26%
Senegal	1b	1	350,000	8,400	2%
Sierra Leone	4	1.7	350,000	16,000	5%
South Africa	6	18.1	2,500,000	1,400,000	56%
Sudan	(None)	1.4	1,800,000	n.a.	n.a.
Suriname	3	2.4	8,900	n.a.	n.a.
Swaziland	4	26.1	96,000	56,000	58%
Tanzania	1	6.2	2,600,000	970,000	37%
Thailand	2	1.4	1,300,000	n.a.	n.a.

Country	Round in Which OVC Were First Included in Approved Proposal Objectives	Estimated Adult HIV Prevalence (%) (age 15 to 49 years), 2007	Children Who Lost One or Both Parents, All Causes, 2007	Children Who Lost One or Both Parents to AIDS, 2007	Children orphaned by AIDS as Percentage of All Orphans
Togo	2	3.3	260,000	68,000	26%
Uganda	1	5.4	2,500,000	1,200,000	48%
Ukraine	6	1.6	1,000,000	n.a.	n.a.
Zambia	1	15.2	1,100,000	600,000	55%
Zimbabwe	(None)	15.3	1,300,000	1,000,000	77%
Zanzibar	6	n.a.	n.a.	n.a.	n.a.

Note: All information on HIV and orphans comes from the UNAIDS Report on the Global AIDS Epidemic (2008); and Children and AIDS: Fourth Stocktaking Report (2009).
n.a. = Data not available.

Table 5. Statistics for Countries with HIV Prevalence under 1 Percent

Country (regional grants list) Primary Recipient	OVC in Approved Proposal Goal and/or Objectives?	Round in Which OVC First Included in Approved Proposal Objectives	Estimated Adult HIV Prevalence (%) (age 15 to 49 years), 2007	Children Who Lost One or Both Parents, All Causes, 2007	Children Who Lost One or Both Parents to AIDS, 2007	Children Orphaned by AIDS as Percentage of All Orphans
Afghanistan	No	–	n.a.	2,100,000	n.a.	n.a.
Albania	No	–	n.a.	n.a.	n.a.	n.a.
Algeria	No	–	0.1	570,000	n.a.	n.a.
Argentina	No	–	0.5	610,000	n.a.	n.a.
Armenia	No	–	0.1	50,000	n.a.	n.a.
Azerbaijan	No	–	0.2	190,000	n.a.	n.a.
Bangladesh	No	–	<0.1	5,000,000	n.a.	n.a.
Belarus	No	–	0.2	190,000	n.a.	n.a.
Bhutan	Yes	6	0.1	22,000	n.a.	n.a.
Bolivia	No	–	0.2	300,000	n.a.	n.a.
Bosnia Herzegovina	No	–	<0.1	n.a.	n.a.	n.a.
Bulgaria	No	–	n.a.	95,000	n.a.	n.a.
Cambodia	Yes	1	0.8	600,000	n.a.	n.a.
Caribbean Community (CARICOM)	Yes	3	n.a.	n.a.	n.a.	n.a.

Country (regional grants list) Primary Recipient	OVC in Approved Proposal Goal and/or Objectives?	Round in Which OVC First Included in Approved Proposal Objectives	Estimated Adult HIV Prevalence (%) (age 15 to 49 years), 2007	Children Who Lost One or Both Parents, All Causes, 2007	Children Who Lost One or Both Parents to AIDS, 2007	Children Orphaned by AIDS as Percentage of All Orphans
Caribbean Regional PLHIV Network	Yes	4	n.a.	n.a.	n.a.	n.a.
Central American Network for PLHIV	No	–	n.a.	n.a.	n.a.	n.a.
Chile	No	–	0.3	160,000	n.a.	n.a.
China	Yes	3	0.1	17,000,000	n.a.	n.a.
Colombia	No	–	0.6	790,000	n.a.	n.a.
Comoros	No	–	<0.1	27,000	<100	n.a.
Costa Rica	No	–	0.4	36,000	n.a.	n.a.
Croatia	No	–	<0.1	n.a.	n.a.	n.a.
Cuba	Yes	6	0.1	99,000	n.a.	n.a.
Ecuador	No	–	0.3	200,000	n.a.	n.a.
Egypt	No	–	<0.1	1,400,000	n.a.	n.a.
El Salvador	Yes	2a	0.8	130,000	n.a.	n.a.
Georgia	No	–	0.1	72,000	n.a.	n.a.
Guatemala	No	–	0.8	360,000	n.a.	n.a.
Honduras	No	–	0.7	170,000	n.a.	n.a.
India	Yes	4	0.3	25,000,000	n.a.	n.a.
Indonesia	Yes	1	0.2	4,400,000	n.a.	n.a.
Iran	No	–	0.2	1,300,000	n.a.	n.a.
Jordan	No	–	<0.2	n.a.	n.a.	n.a.
Kazakhstan	No	–	0.1	470,000	n.a.	n.a.
Kosovo	No	–	n.a.	n.a.	n.a.	n.a.
Kyrgyzstan	No	–	0.1	140,000	n.a.	n.a.
Lao People's Democratic Republic	No	–	0.2	210,000	n.a.	n.a.
Lutheran World Federation	No	–	n.a.	n.a.	n.a.	n.a.
Macedonia	No	–	<0.1	n.a.	n.a.	n.a.
Madagascar	Yes	3	0.1	840,000	3,400	0.4%

Country (regional grants list) Primary Recipient	OVC in Approved Proposal Goal and/or Objectives?	Round in Which OVC First Included in Approved Proposal Objectives	Estimated Adult HIV Prevalence (%) (age 15 to 49 years), 2007	Children Who Lost One or Both Parents, All Causes, 2007	Children Who Lost One or Both Parents to AIDS, 2007	Children Orphaned by AIDS as Percentage of All Orphans
Maldives	Yes	6	n.a.	8,800	n.a.	n.a.
Mauritania	Yes	5	0.8	83,000	3,000	4%
Mesoamerica	No	–	n.a.	n.a.	n.a.	n.a.
Moldova	No	–	0.4	74,000	n.a.	n.a.
Mongolia	No	–	0.1	64,000	n.a.	n.a.
Montenegro	No	–	n.a.	n.a.	n.a.	n.a.
Morocco	No	–	0.1	630,000	n.a.	n.a.
Myanmar	Yes	3	0.7	1,600,000	n.a.	n.a.
Nepal	Yes	2	0.5	990,000	n.a.	n.a.
Nicaragua	No		0.2	110,000	n.a.	n.a.
Niger	Yes	7	0.8	570,000	25,000	4%
Organization of Eastern Caribbean States (OECS)	No	–	n.a.	n.a.	n.a.	n.a.
Western Pacific (Cook Islands, Micronesia, Fiji, Kiribati, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu)	Yes	2	n.a.	n.a.	n.a.	n.a.
Pakistan	No	–	0.1	3,900,000	n.a.	n.a.
Paraguay	No	–	0.6	130,000	n.a.	n.a.
Peru	Yes	5	0.5	570,000	n.a.	n.a.
Philippines	No	–	<0.1	1,800,000	n.a.	n.a.
Romania	No	–	0.1	300,000	n.a.	n.a.
São Tomé and Príncipe	Yes	5	n.a.	n.a.	n.a.	n.a.
Serbia	No	–	0.1	130,000	n.a.	n.a.
Somalia	Yes	4	0.5	590,000	8,800	2%
Sri Lanka	No	–	<0.1	330,000	n.a.	n.a.
Tajikistan	No	–	0.3	210,000	n.a.	n.a.

Country (regional grants list) Primary Recipient	OVC in Approved Proposal Goal and/or Objectives?	Round in Which OVC First Included in Approved Proposal Objectives	Estimated Adult HIV Prevalence (%) (age 15 to 49 years), 2007	Children Who Lost One or Both Parents, All Causes, 2007	Children Who Lost One or Both Parents to AIDS, 2007	Children Orphaned by AIDS as Percentage of All Orphans
Timor-Leste	No	–	n.a.	48,000	n.a.	n.a.
Tunisia	Yes	6	0.1	130,000	n.a.	n.a.
Turkey	Yes	4	<0.2	n.a.	n.a.	n.a.
Uzbekistan	No	–	0.1	690,000	n.a.	n.a.
Vietnam	No	–	0.5	1,500,000	n.a.	n.a.
West Africa Corridor Program	Yes	6	n.a.	1,500,000	n.a.	n.a.
West Bank and Gaza	No	–	n.a.	n.a.	n.a.	n.a.
Yemen	No	–	<0.2	n.a.	n.a.	n.a.

Note: All information cited from UNAIDS Report on the Global AIDS Epidemic (2008).

Representatives of OVC in CCMs of Countries Proposing OVC Objectives

As shown in Table 1, 38 of the 122 countries (31%) with HIV grants in Rounds 1 through 7 included OVC representatives (such as NGOs serving children or the Ministry of Child Welfare) on their CCMs. Sixteen countries with OVC representatives on their CCMs submitted proposals with OVC objectives, with West and Central Africa accounting for 14 of those countries and South Asia and East Africa and the Indian Ocean accounting for the remaining 2 countries. West and Central Africa claimed the greatest number of approved grants with OVC objectives (26), followed closely by East Africa and the Indian Ocean (25). Given the limited number of cases, it is an open question as to whether the inclusion of OVC representatives in CCMs influenced the submission of proposals with OVC objectives. It should be noted that East Africa and Indian Ocean had only one CCM with OVC representation, yet the region received approvals for nearly the same number of proposals with OVC objectives as did West and Central Africa.

Inclusion of OVC Goals/Objectives in Grant Agreements

Once the original proposals gain approval, it is important to understand whether, why, and how the proposals' goals and objectives are carried over into the grant agreements, which outline each grant's objectives, strategies, target beneficiaries, and baseline and target indicators. The mechanics and nuances of the grant approval negotiation process could not be reviewed in this study on a grant-by-grant basis, although this may provide important information regarding the nature of the inclusion or exclusion of OVC objectives and targets throughout the course of the grant.

Table 6 presents a summary comparison of grant agreements with original proposals (the agreements for 13 grants were not available on the web site at the time of the study). Sixty-four of the grants with OVC objectives in their proposals (55%) carried over the objectives into the grant agreements.

Table 6. Comparison of OVC Goals/Objectives in Approved Proposals and Grant Agreements

Inclusion of OVC Objectives	Number of Grants
OVC goals/objectives in proposals and grant agreements	64
OVC goals/objectives in proposals but not in grant agreements	39
OVC goals/objectives in proposals but grant agreements not available	13
SUBTOTAL	**116**
No OVC goals/objectives in proposals but in grant agreements	13

Thirty-nine grants (34%) that included OVC goals/objectives in their proposals did not carry them over into their grant agreements. Thirteen (13) proposals without OVC goals/objectives in their proposals did include them in their grant agreements. The Global Fund web site's database did not allow the research team to determine why OVC goals/objectives were included in grant agreements. In addition, the research team could not determine whether the 39 grants that included OVC goals/objectives in their proposals but not in their grant agreements undertook activities that included or had some impact on OVC. In total, 77 grant agreements included OVC goals/objectives.

Content, Target Population, Interventions, and Approaches

The milestones summarized in Annex 2 highlight a key shift in OVC interventions and approaches. With growing knowledge about the HIV epidemic and an increasingly multisectoral and holistic response to it, "OVC care and support" expanded to include interventions beyond medical care and treatment and now refer to social protection, food and nutrition, schooling, psychosocial care, housing, clothing, and/or monetary assistance.

The research team examined the 77 grants with OVC goals/objectives in their grant agreements in order to ascertain the specific services or interventions that were proposed, the OVC groups that were the target of the interventions, whether an individual or family approach was to be employed, and whether community or local networks were to be harnessed. It should be noted that most approved HIV grants with OVC objectives did not provide detailed information about OVC-related issues, target groups, approaches, strategies, and interventions. Many proposals were broadly written; thus, it is possible that the intent was to develop specific activities upon project implementation or identify needs in specific areas. Limited OVC awareness, understanding, evidence, or expertise in describing proposals' OVC components may have contributed to the lack of specifics about OVC targets, interventions, and strategies or confidence in reporting on them.

Of the 77 grant agreements with OVC goals/objectives, the research team could categorize only 18 grants as clearly "OVC-focused"; in other words, the grant agreements not only included the OVC objectives outlined in the proposals but also described OVC-specific strategies, interventions, and activities and included OVC information in disbursement requests and/or performance reports. Thus, the 18 grants retained OVC content across the entire life-cycle of the grants (see Table 7).

The 18 OVC-focused grants used OVC to refer to their target populations, which could be orphans, children of those living with HIV, HIV-positive children, or children in foster or institutional care. The most common reference, however, was orphans. Within the set of 18 grants, countries with high HIV

prevalence, such as Swaziland, Lesotho, Botswana, Tanzania, and Kenya, tended to focus on children orphaned by AIDS.

Table 7 further reveals that 12 grants specified broad care and support services; 11 noted prevention services; 10 called for livelihood training or related support; and 7 planned for social protection services. The research team tried to ascertain whether Global Fund grants link or integrate various OVC care and support services and discovered that it is not clear from the grant proposals and grant agreements how different types of services were to be delivered, especially as the services are the responsibility of different sectors, staff, and/or mechanisms.

Table 7. Global Fund Grants with Defined OVC Focus Based on Objectives and Strategies by Country, Round, Age/Gender Focus, and Approaches

Country and Round	Specific Age or Gender Focus	Content of Care and Support Interventions*	Key Service Delivery Mechanism
Benin 2	n.s.	Mitigation, care and support, education, livelihood training	NGOs and community
Benin 5	OVC < 18 years	Mitigation, care and support, social integration, education, livelihood training	Local NGOs and institutions
Botswana 2	n.s.	Mitigation, link to PMTCT and antiretroviral treatment, education, livelihood training, institutional care	NGO caregivers, community-based organizations, health workers
Cambodia 1	n.s.	Mitigation, care and support, education, vocational training and income-generating activities	Community foster family network
Cambodia 5	n.s.	Scaled-up provision of a range of OVC services	Local institutions, community networks
Cambodia 7	OVC <18 years	Scaled-up prevention, treatment, care and mitigation for vulnerable and marginalized populations at risk	Local institutions, community network
Cameroon 3	n.s.	Economic, psychosocial support, medical care, family fostering	Orphanages, local NGOs, community-based organizations
Cameroon 4	OVC <18 years	Care and support, livelihood	Community groups and faith-based organizations
Central African Republic 4	n.s.	Mitigation, care and support, livelihood, social protection	Legal institutions and staff
India 6	n.s.	Home- and community-based care, psychosocial counseling, basic medical care, livelihood	Local institutions and community network
Kenya 1	n.s.	Education, shelter, food, clothing, legal services	Local NGOs and community organizations

Country and Round	Specific Age or Gender Focus	Content of Care and Support Interventions*	Key Service Delivery Mechanism
Lesotho 2	Sex disaggregation	Social protection, foster parenting, food baskets	Faith- and community-based care
Lesotho 7	OVC <18 years; sex disaggregation	Mitigation, care and support, livelihood, linkage to PMTCT	Health and community workers
Malawi 5	n.s.	Social protection policy development, institutional care and support, mitigation, livelihood	Legal institutions and staff
Swaziland 4	n.s.	Care and support, early childhood development, education, mitigation, livelihood	Health and community workers
Swaziland 7	n.s.	Psychosocial support, social protection, mitigation, care and support	Social support to community
Tanzania 4 (a)	Sex disaggregation	Social protection, mitigation, care, livelihood	Multisectoral, community
Tanzania 4 (b)	Sex disaggregation	Legal protection, mitigation, care and support, treatment	Multisectoral, community

n.s. means not specified.

It should be noted that local NGOs are key implementers, demonstrating the need for governments to get involved as key social policy drivers to upscale actions for children affected by HIV and AIDS.

Age and Gender of Target Populations

As Table 2 shows, few grants with OVC content included information on age and gender. Only 29 out of the 261 HIV/AIDS grants (11%) provided age-specific information, with most age references appearing only in the grant proposals as opposed to related documents.

The age groupings of OVC are important for program and planning purposes in the context of the growing emphasis on child development approaches and the need to integrate or link OVC services for specific ages. While grant agreements specifying OVC activities or objectives adopted the age cut-off of 18 years,[9] proposals, grant agreements, and GPRs generally did not distinguish OVC needs or services according to age and gender within that 18-year age span. Several grant agreements with an OVC focus emphasized education and/or training but did not acknowledge that children's learning needs vary with age.

For example, livelihood training and HIV prevention are most appropriate for older OVC. In fact, several countries proposed such services albeit in the absence of related support services such as job placement or seed capital. Obviously, the growth, learning, social, and emotional needs of children in early childhood are markedly different from those of older children, the more so for very young orphans and children dealing with chronically ill parents or caregivers. Yet, hardly any projects specified early childhood development programs, with Swaziland as an exception. Even during the initial funding rounds, Swaziland proposed OVC interventions that included early child development. Several grant agreements related to the 18 grants mention psychosocial care, but grant documents did not describe the specific services to be provided and whether such services were to respond to the varying needs of girls and boys across age sets.

[9] The age set from birth to age 17 used by several countries when referring to OVC is likely in keeping with the CRC.

Only 35 of the 261 grants (13%) made some reference to gender, of which 31 primarily referred to gender in their proposals. Tanzania's Round 4 grant is a good example of defined age and gender considerations in proposed OVC interventions (see Box 1).

Box 1. Excerpts from Tanzania's Round 4 Proposal

Background. "Tanzania has one of the highest HIV pandemics in the world. Although estimated adult prevalence stabilized in the mid-1990s at 10.5%, the number of PLHA and AIDS deaths continued to grow. Young people age 15-24 years comprised 60% of new HIV infections, with girls six times more likely than boys to be infected. By end of 2004, two million AIDS deaths had occurred, with deaths among women surpassing those among men. The alarming numbers of AIDS deaths resulted in large numbers of children affected and orphaned by AIDS. Girls tend to drop out of school to care for family members. They are particularly susceptible to sex in order to survive and meet their own and their family's needs. Girls are also more likely to miss out on inheritance rights; they may have less access to legal advice because of cultural attitudes that girls should not inherit. Tanzania's national multisectoral framework includes policy reform to protect the rights of women and children affected by HIV and to ensure an enabling environment for OVC."

OVC Objectives of Proposal. "To reduce the adverse effects of HIV/AIDS, poverty, exploitation and abuse of orphans and children identified as most vulnerable. To promote gender equality and empower women by addressing the primary, secondary and vocational educational needs of girl orphans, girl heads-of-households and girl family-caregivers while striving to reduce their exposure to high-risk behavior and work through livelihood programs and basic support."

Strategy for OVC Component. "Using the National Policy on Gender and Equity as a framework, the proposed programming will focus on 20 districts. Interventions would focus on those with the least access or greatest difficulty in accessing services--those who are out of school, most economically disadvantaged and malnourished. Both boys and girls were to be targeted, with different emphasis based on gaps in services reaching them or their ability to access services. Targeting the psychosocial needs of girl children was emphasized because children affected by HIV/AIDS become vulnerable long before their parents die. A network of 20 NGO/FBO partners will work with the Department of Social Welfare and local councils to implement the program. Communities will conduct the identification process and develop support mechanisms to respond to the 300,000 most vulnerable children in these districts."

Approaches and Mechanisms

The global milestones marking the OVC response include recent calls for developmental approaches that are family-centered rather than targeted to the individual and that are channeled through local mechanisms such as social or community networks. The emphasis on the family is intended to build the capacity of not just OVC but also of parents and caregivers to be able to care for OVC. Local community, social, and neighborhood networks play an important role in ensuring the delivery of care. Such groups know what is happening in the community, can identify orphans and other vulnerable children in need, and can coordinate, support, or monitor the provision of services or referrals to OVC. In many countries with scarce resources, community networks are already caring for OVC (JLICA, 2009).

To what extent do OVC-focused grants rely on family-oriented or community network approaches? All 18 grants cite the importance of working closely with or involving NGOs and community networks in OVC activities but provide limited information beyond that. Nearly all mention collaboration or coordination but do not specify the coordination mechanisms that projects will use to meet the varied needs of OVC. However, problems with OVC service linkages, referrals, and collaboration are not unique to Global Fund–supported efforts. The discussion on milestones and issues suggests that such problems affect OVC programs in general.

Funding Issues

OVC budget parameters in the Global Fund's database are not always clear and can vary widely. Table 2 showed that 56 out of 261 approved HIV/AIDS grants (21%) included budget-related information referring to OVC, but budget information tied to OVC programming was sparse. Some grant proposals listed a flat dollar amount to be allocated for OVC, as in Ethiopia's Round 2 grant, which included $540,000 for OVC support. Cameroon's Round 3 grant of $67,000 aimed to reach 10,000 OVC in families and orphanages for one year. The Comoros's Round 3 grant included $10,000 to provide food to PLHIV, children, and orphans. Guinea-Bissau's Round 7 grant listed $3.7 million over five years for OVC support while Uganda's Round 3 grant noted $56 million over three years for its OVC subcomponent. The West Africa Corridor's Round 6 grant included $240,000 in the first year, $840,000 each in the second and third years, $940,000 in the fourth year, and $840,000 in the fifth year.

Other grants assigned a rate per child or family. Haiti's Round 5 grant used $50 per orphan per month to cover 20,000 orphans under its $19 million grant. Djibouti's Round 6 grant estimated $30 per OVC reintegration kit and trade learning per year to reach 500 children. DRC's Round 7 grant estimated $25 per person for food rations and $100 per household for school kits that included uniforms. Dominican Republic's Round 2 grant estimated the cost of supplemental care and supplies at home and in school for orphans and children infected or affected by HIV at $300 per person per year.

For most countries, the exact amounts allocated by Global Fund grants for specific OVC activities proved difficult to ascertain. In several instances, OVC-related concerns were folded into multiple objectives for which budgets were not detailed or specific line items provided (for example, Nepal's Round 7 grant for a supportive policy environment). In other instances, OVC-related costs were included in line items such as youth in general, education, or training. For example, the Lutheran World Foundation's Round 1 grant included $125,000 to train church leaders who would undertake various activities targeted to OVC as potential beneficiaries. Several grants included budget items for broad objectives that benefit children in general (e.g., to improve the health of mothers and children and support PMTCT services or child healthcare). At times, disbursement requests included OVC objectives, but the research team's review yielded no evidence of OVC-related activities or expenditures. Table 2 indicates that only 38 out of 261 approved grants (15%) included OVC in disbursement requests.

Table 8 presents overall funding-related information for the 18 Global Fund grants with clearly defined OVC objectives and focus. Most countries received approval for the grant amounts requested for OVC-related HIV activities. It should be noted, however, that, even though these grants focused on OVC, 11 of the 18 were to fund or scale up a national HIV response usually involving a broad array of programs and services for HIV prevention, treatment and care, and impact mitigation.

The remaining 7 of the 18 grants can be categorized as primarily OVC grants; as their titles suggest, the grants specified objectives, strategies, and activities centered mainly on care and support services for OVC. The grants were submitted by Cambodia, Central African Republic, India, Lesotho, Malawi, Swaziland, and Tanzania.

The research team examined the documents for the 18 OVC-focused grants to identify the reasons for disbursement delays and discovered that country plans and programs were partly at fault for failing to formulate the M&E and procurement and supply management plans that are required in advance of disbursement. In addition, the research team examined the 18 grants to determine which countries did not receive the amount of funding originally requested. Even with India's large total population and, along with China, the world's largest number of orphans (there are no recent estimates of orphans due to AIDS for the two countries, but estimates of orphans due to all causes are available, including 25 million for

India alone in 2007), India's Round 6 grant was approved only for a fraction of the total funding requested despite a clearly defined OVC focus in its proposal and grant agreement.

Similarly, Lesotho and Swaziland both have high adult HIV prevalence and large proportions of children orphaned by AIDS among all orphans. Lesotho's Round 7 proposal included $33 million for HIV prevention and impact mitigation for OVC but was approved for only $10.6 million. Swaziland's Round 7 proposal requested $82 million for a project on vulnerable children but received approval for only $23 million. The Round 4 grant for Tanzania, which also has high HIV prevalence (although lower than Lesotho or Swaziland) and a large proportion of orphans due to AIDS, initially received approval for $55 million for OVC compared to its original request for $283 million. However, an additional Round 4 grant was approved for $184 million, with the funds to cover OVC as well as condom procurement, care and treatment, M&E, and national coordination.

Table 8. Global Fund Grant Agreements with Defined OVC Focus by Country, Project Title, and Budgets

Country and Round	Grant Titles/Key Elements	Total Budget Requested in US$ (million)	Total Budget Approved in US $ (million)	Specific Amount Budgeted for OVC Programming in US $ (million)
Benin 2	Intensification of fight against HIV/AIDS	17.3	17.3	n.a.
Benin 5	Intensification of fight against HIV/AIDS	55.6	55.6	3.5
Botswana 2	Scaling up the multisectoral response to HIV/AIDS	18.6	18.6	0.6 For OVC-specific activities
Cambodia 1	Partnership for going up to scale with proven interventions for HIV/AIDS, TB, and Malaria	14.7	14.7	n.s.
Cambodia 5	Scale up of prevention, care, and treatment for vulnerable and marginal populations	46.7	23.9	n.s.
Cambodia 7	Scale up to increase coverage in key areas	35	35	n.s.
Cameroon 3	Scaling up treatment and care of PLHIV	55.5	55.5	6.0 Total for years 3 through 5
Cameroon 4	Civil society mobilization to fight HIV/AIDS	16.2	16.2	n.s.
Central African Republic 4	Strengthening care of orphans and other children affected by HIV/AIDS	10.7	8.5	4.7 Two-year total

Country and Round	Grant Titles/Key Elements	Total Budget Requested in US$ (million)	Total Budget Approved in US $ (million)	Specific Amount Budgeted for OVC Programming in US $ (million)
India 6	Scaling up care and support for children living with and/or affected by HIV/AIDS	259.2	13.9	8.3
Kenya 1	Community mobilization to fight HIV/AIDS	220.9	220.9	n.s.
Lesotho 2	Strengthening prevention and control	29.3	29.3	n.s.
Lesotho 7	Preventing HIV and mitigating impact among OVC	33.2	10.6	33.2 (from proposal, including principal recipient costs of $2,507,0000)
Malawi 5	Health systems strengthening and orphan care and support	17.6	17.6	17.6
Swaziland 4	Scale up key components of the national response	45.8	45.8	n.s.
Swaziland 7	Empower PLHIV, OVC, women, girls, and other vulnerable groups	81.9	23.4	43.9 (from proposal)
Tanzania 4 a	Filling critical gaps in impact mitigation response for OVC	283.1	55.7	52.8 (91% per proposal)
4 b	Filling critical gaps in impact mitigation response for OVC, condom procurement, care and support		184.2	52.8 (91% per proposal)

n.s. means not specified

Performance Reports and Results

Table 2 indicates that 53 of the 261 HIV/AIDS grants (20%) approved in Rounds 1 through 7 included OVC goals/objectives in their grant agreements *and* corresponding OVC targets in their GPRs. In addition, 24 grants made no mention of OVC in their grant agreements, although their GPRs cited some OVC targets. Thus, 77 of the 261 HIV/AIDS grants (30%) involved GPRs with OVC targets. It should be noted, however, that the 77 grants referred to here are not always the same 77 grants described above with OVC goals/objectives in their respective grant agreements. Table 9 summarizes available information related to progress toward OVC targets reported in GPRs. The GPRs for 35 of the 77 grants (46%) reported that grant-funded activities either met or exceeded their OVC targets.

Table 9. Progress toward OVC Targets*

GPR Information on Progress toward Targets	East Africa and Indian Ocean	Southern Africa	West and Central Africa	South Asia	East Asia and Pacific	Eastern Europe and Central Asia	MENA	LAC	Lutheran World Federation	Total
Targets listed	12	16	21	1	8	2	7	9	1	77
Results below targets	3	3	5	0	2	0	3	1	0	17
Results that met or exceeded targets	0	9	13	1	5	0	1	6	1	36

*Note: Only 53 of the 77 grants provided information on results/targets achieved at the time of the desk review.

Only 5 among the 18 OVC-focused grants (28%) met or exceeded their OVC targets: Cambodia Rounds 5 and 7; Cameroon Round 3; Lesotho Round 2; and Malawi Round 5. While Malawi's grant focused on health systems strengthening and orphan care, the other grants requested assistance for general scale-up, with OVC interventions comprising the care and support component.

The other grants with GPRs that reported specific grants that met or exceeded their OVC targets included the following:

- **Countries with HIV prevalence greater than 10 percent (mostly in Southern Africa, e.g., Mozambique, Namibia, and South Africa).** The grants were to fund each country's HIV prevention, voluntary counseling and testing, treatment, and care and support programs. The countries have large proportions of children orphaned by AIDS among all orphans.
- **Countries with HIV prevalence between 1 and 10 percent.** Most such countries are located in Africa—Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Ghana, Liberia, Senegal, and Sierra Leone—but others such as Haiti and Suriname fall into the same category and proposed to address the needs of orphans as a consequence of AIDS.
- **Countries with HIV prevalence below 1 percent.** Grants to countries such as Cuba, El Salvador, and Peru included efforts to reach vulnerable children.

The information in Table 10 for the 14 grants with GPRs that reported not meeting their OVC objectives/targets is instructive.[10] Five GPRs cited problems related to OVC data—Cambodia (Rounds 1 and 2), Costa Rica, Gambia, and Guinea. Data problems included the lack of reliable estimates of orphans or children living with HIV and children otherwise affected by HIV and AIDS, children with the loss of a family member, age breakdowns of affected children, and the location of children. Four GPRs (Benin, DRC, and Zambia Rounds 1 and 4) cited delays in Global Fund disbursements and thus delays in implementing proposed interventions and programs. Three other country GPRs stated that it was too soon to report OVC results.

The detailed GPRs of Benin Round 5 and Tanzania Round 4 are accompanied by related documents that help explain some of the factors that affected grant implementation. It should be noted that both countries implemented grants with a clear OVC focus (see Table 7). Benin's grant targeted 9,000 children orphaned by AIDS with school fees and supplies and reached 5,189 with school fees and 450 with professional

[10] It should be noted again that this reporting does change over time and so new information is being constantly posted, changed, and re-posted to the Global Fund web site.

training fees. Delays in signing the Round 5 grant led to Benin's inability to reach its OVC targets. In October 2008, two independent firms conducted an exercise to review the list of eligible OVC and produced a list of 10,725 children identified as OVC for Benin.[11]

Tanzania's grant focused on implementing national policies and programs to promote and protect the rights of OVC. Tanzania used a significant portion of its grant funds to establish structures country-wide for coordination and partnership development down to the community level, including the formation and development of OVC village committees and the training of justice facilitators. The most recent GPR showed that the project achieved an 85 percent performance rate (up from 23% in earlier years). Tanzania has undertaken noteworthy OVC efforts that involve community participation in identifying vulnerable children and their needs (MEASURE, 2009; USG, 2009).

Table 10. GPR Data on 14 Grants Not Meeting OVC Targets

Country	Round	Grant Title or Main Content	Reason(s) for Not Meeting OVC Objectives or Targets as Gleaned from GPRs and Other Global Fund Documents
Angola	4	Reducing the HIV/AIDS burden	Not clear; GPR states only a need for "more effort and creativity" (page 37).
Benin	5	Intensification of fight against HIV/AIDS	Funds were frozen, hence activities were delayed. Targeted 9,000 children orphaned by AIDS supported with school fees and supplies; reached 5,189 (page 16).
Cambodia	2	Continuum of care	Limited data on children ("HIV infection and loss of family member") affected implementation (page18).
Cambodia	1	Partnership to scale-up TB, HIV/AIDS, and malaria interventions	No specific explanation for OVC target, but procurement issues often cited in other parts of GPR (page 9).
Costa Rica	2	Strengthening HIV/AIDS response	Data problems in that official HIV/AIDS database did not allow analysis by geographic location and age. Problems impeded identification of HIV-positive school-age children within geographic areas used by the Ministry of Education (page 7).
DRC	7	Decentralization and implementation of PLHIV prevention and care	Funding disbursement delayed by non-fulfillment of certain conditions related to plan to support victims of sexual violence. Delays resulted in budget reduction for health products and legal aid for victims (page 12).
Gabon	3	Strengthening initiative against HIV/AIDS	SR had to be changed to ensure a more efficient program in response to previous delays in reaching targets for orphans receiving nutrition and education support (page 17).
Gambia	3	Treatment, care, and support for PLHIV and people affected by HIV	Problems with OVC data led to delays in introducing OVC program at regional centers and need to verify number of OVC receiving external support. A new OVC register was adopted (page 30).
Guinea	6	Strengthening fight against HIV/AIDS	Data and programming issues, especially number of OVC receiving school support, essential when schools undertake OVC programming; no OVC activities when schools are closed.

[11] See http://www.theglobalfund.org/grantdocuments/5BENH_957_517_gpr.pdf, accessed January 20, 2010.

Country	Round	Grant Title or Main Content	Reason(s) for Not Meeting OVC Objectives or Targets as Gleaned from GPRs and Other Global Fund Documents
Rwanda	7	Universal access to integrated HIV/AIDS services	No reports yet (page 210).
Rwanda	6	Decentralization of care and treatment for PLHIV	No reports yet (page 3).
Tanzania	4	National response to HIV/AIDS in impact mitigation for OVC	No reports yet (page 21).
Zambia	1	Program to combat HIV/AIDS	Delays in disbursements from Global Fund (no reason cited).
Zambia	4	Churches Health Association of Zambia (CHAZ) program to combat HIV/AIDS	Delays in disbursements from Global Fund (no reason cited).

SUMMARY AND RECOMMENDATIONS

The desk review found that 116 of the 261 approved grants (44%) in Rounds 1 through 7 originally submitted proposals that addressed OVC objectives. Sixty-eight of the 116 approved proposals (59%) with OVC goals or objectives came from sub-Saharan African countries—most of which face generalized HIV epidemics and significant proportions of children orphaned by AIDS. However, countries in other regions, most of which have low HIV prevalence, also set forth OVC objectives in their proposals. Grant agreements, however, did not necessarily incorporate the OVC objectives outlined in the proposals. In total, 77 grant agreements contained OVC objectives, including 64 with OVC objectives in both the proposal and grant agreement and 13 with OVC objectives in the grant agreement but not in the proposal.

Most approved grants were intended to fund the national response to HIV/AIDS, with OVC objectives among several other objectives. Proposals were often broadly written, possibly allowing for more specific activities to be developed upon implementation or as needs were identified during implementation, especially in the case of grants involving multiyear activities. In some countries, lack of OVC data affected the implementation of OVC activities. Often, key barriers limited efforts to address the OVC components of proposals even in countries with some experience in OVC interventions (see Table 10).

Only 18 of the 261 Global Fund grants (7%) in Rounds 1 through 7 were OVC focused; that is, in addition to setting forth OVC objectives, the grants specified the OVC strategies and interventions that they proposed to employ. Most of the 18 grants focused on children living with as well as affected by HIV. The grants tended to focus on mitigation, schooling, and livelihood training. OVC experts emphasize the importance of employing developmental approaches geared to the specific age and gender groupings of OVC. The review revealed that several OVC-focused Global Fund grants have adopted a family focus in place of targeting individual orphans. Another encouraging note, likely reflecting the multisectoral orientation of many HIV/AIDS programs, is the emphasis of Global Fund grants on OVC interventions that involve social and community networks.

The data also show that some of the 18 approved OVC-focused grants did not receive the full funding requested but that grants with some OVC components—often as part of broader projects involving a wide

array of HIV/AIDS prevention, treatment, and impact mitigation activities—often received full funding. Some of the difficulty in addressing or obtaining funding for OVC can be linked to the limited data on OVC—whether children orphaned by AIDS or other circumstances—and other vulnerable children. Another challenge lies in the nature of OVC interventions and provider mechanisms. Unlike prevention, voluntary testing and counseling, and treatment services that rely significantly on health providers and clinical infrastructure, OVC care and support largely relies on community networks and family structures. To a certain extent, reliance on such sources may explain why the amount of funding allocated for OVC activities in Global Fund grants is not clear. The budget information for most grants is often stated in broad terms, and OVC-related activities are often part of other activities.

In summary, although government departments and agencies associated with children's development are included in some CCMs, it could not be determined to what degree they represent or advocate for children. Local child advocacy groups, supported by technical partners and international agencies, should be assisted to join CCMs and be more active on behalf of children. There is also a need to increase country demand for funds to provide mitigation for children infected and affected by HIV. Only 7 percent of grants were identified as OVC focused. Proposals are often non-specific and OVC are often part of the overall national HIV plan. Countries need technical assistance from multi-lateral and other technical agencies on specific actions required for OVC. Most grants are implemented by NGOs and more support, participation, and prioritization is needed by governments, as advocated by JLICA. Grants are also limited in scope and target very small numbers of those affected. Broad social policy interventions, social protection that increases access to schooling, healthcare, and citizen documentation as well as direct supportive services to families to assist children are needed. The paucity of data and lack of indicators may lead to OVC targets being dropped in negotiations of final agreements. The child-focused international community needs to give urgent attention to developing a core set of feasibly-collected indicators and work with countries to have these incorporated. Some grants also do not have a good record of achieving OVC-related targets. Future work should examine factors that distinguish those country programs that are successful so other countries can learn from them. Data difficulties are also cited as contributing to poor performance.

Based on the findings from the desk review, Table 11 lists key challenges identified in the report and corresponding recommendations for action.

Table 11. Challenges and Recommendations

Specific Challenges	Recommendations
1. **OVC data**—Countries need assistance to obtain precise estimates of and data about vulnerable children. The lack of a published country-level, operational definitions of OVC constrains countries' ability to plan, seek funding, develop indicators, and set targets and implement programs. • Many developing countries with high HIV prevalence focus on orphans due to AIDS and children living with HIV. However, in view of data related to vulnerability factors including poverty, many more children are highly vulnerable but not targeted. • Countries with low HIV prevalence are also constrained by lack of data and prioritization.	Regional, country, and community OVC advocates should support data collection that can inform a clear, evidence-based country-specific definition of OVC and related needs and gaps. Defining OVC must also take into consideration a holistic view of OVC from multiple vulnerability factors, including poverty and gender, and OVC as individuals and members of communities and vulnerable families. Stakeholders, including CCMs, need to link with technical agencies to develop operational definitions and performance data that can be used by the Global Fund and other donors.

Specific Challenges	Recommendations
2. Including OVC in proposals and grant agreements— • Fewer than half of countries included OVC goals or objectives in their proposals. • Countries tend to treat OVC as a homogeneous or generalized group rather than as groups with age- and gender-related issues at various stages in life. • While the Global Fund has gender strategies, it does not have an OVC strategy.	Partners and stakeholders should urge the Global Fund to develop an OVC strategy. OVC technical partners as well as UNICEF and USAID can also provide explicit guidance on how countries can include OVC issues in their proposals. Such a guide can feature illustrative examples of OVC objectives and how objectives may be achieved by, for example, focusing on specific age groups or gender issues as well as structural vulnerability factors such as poverty. Summaries of promising OVC approaches, such as family-centered initiatives or those coordinated by community networks in specific countries, would be helpful. Such a guide could also provide a resource for effective OVC representation in CCMs and a tool for information sharing and advocacy for OVC advocates. Further, while UNAIDS and WHO are listed as technical partners for the Global Fund, UNICEF is not, but could serve as a strong technical partner to support OVC program proposals in country, in particular. Understanding the negotiation process from proposal to grant agreement would benefit stakeholders and OVC champions to ensure OVC do not drop off the grant after the proposal is awarded. Researchers and agencies working with the publicly available data on Global Fund grants and CCMs can also support broader dissemination and easy access to best practices that provide practical, replicable examples of programming and lessons learned. Better data collection, as mentioned in recommendation 1 above, will allow for more confidence at the country level to develop realistic OVC indicators and clear targets that will, in part, also address the erosion of OVC inclusion in the grant process, from proposal to legally-binding performance reporting.
3. Representation—Only about 31 percent of CCMs had OVC representation.	OVC advocates and stakeholders must be effectively represented in CCMs. In addition to national-level stakeholders, regional organizations and networks can advocate for OVC champions to be included on CCMs. Country-level stakeholders and champions can make a difference by advocating for the inclusion of active OVC representatives on CCMs, evidence-based decisionmaking including OVC-specific data collection, and OVC inclusion in grants, grant agreements, budgets, and performance reporting as appropriate.
4. Budgeting OVC activities—The budgets for OVC activities in grants are often folded into budgets for other activities. Some grants break out budget information for OVC, but budget	Capacity building needs to be provided by technical partners to support costing exercises based on data as mentioned in recommendations 1 and 2 above. Countries can benefit significantly from seed funding for OVC costing exercises for

Specific Challenges	Recommendations
parameters and specific allocations are often not clear.	improved estimation of resource needs. Clear reporting is needed to monitor funds spent to meet OVC objectives; funding flows also need to be tracked and shared.
5. Complicated disbursement requirements — Some countries reported delays in the implementation of OVC activities due to Global Fund CPs or disbursement processes.	PRs and sub-recipients can benefit from capacity building at the regional level regarding Global Fund requirements for grant signature and disbursements. Processes need to streamlined and/or simplified. For example, the GFATM requires countries to have M&E and procurement and supply management plans in place before it makes disbursements. Considering the data and resource challenges associated with OVC, many countries would benefit from knowing about the Global Fund funds available to support advocacy for the development of such a policy or planning.
6. Advocacy—There is a need for stronger advocacy around OVC inclusion in Global Fund processes, strategies, guidance, and grants.	Potential OVC champions at the country level must be trained around evidence-based advocacy, linking to recommendations 1, 2, and 3 above. Special attention should be paid to broader vulnerability factors including poverty and steps needed beyond treatment access to ensure human security for orphans and their family members who are also vulnerable, such as mothers and fathers living with HIV.
7. Limited M&E of OVC initiatives—Proposals and even performance reports lack information on how OVC targets were developed and how results or targets were achieved, although information tended to be available on why targets were not achieved.	Given countries' limited resources and the technical requirements of M&E, monitoring and evaluation of OVC programs requires considerable support. While there have been initiatives to improve M&E, the capacity needs to be built around M&E and OVC which should also be included in guidance mentioned in recommendations 1 and 2 above. More robust reporting and the development of indicators and participatory processes that include beneficiary inputs would improve overall M&E.
8. Limited information regarding OVC for all grants	While the desk review focused on HIV/AIDS grants, it should be broadened to include tuberculosis, malaria, and HSS grants. Further, an expanded search to analyze programming for all people under the age of 18 would also provide much needed information regarding highly vulnerable children, adolescents, and youth populations such as street children who may not be orphaned but face high vulnerability. A holistic approach to vulnerability should include affected families and communities, and vulnerability factors such as poverty.

ANNEX 1. APPROVED PROPOSALS WITH OVC OBJECTIVES BY REGION AND ROUND—DATA SHEET FOR FIGURE 7

Round	East Africa and Indian Ocean	South-ern Africa	West and Central Africa	South Asia	East Asia and the Pacific	Eastern Europe and Central Asia	MENA	LAC	Total
1	3	5	2		3				13
2	2	6	4	1	5			1	19
3	3		3		2		2	3	13
4	5	2	3	2	1	1	3	1	18
5	2	1	5		2		1	2	13
6	4	1	7	5	1	1	2	1	22
7	6	2	2	3	2		1	2	18
Total	25	17	26	11	16	2	9	10	116

ANNEX 2. GLOBAL MILESTONES IN THE OVC RESPONSE

The following is a chronology of OVC-related events:[12]

1989. The United Nations adopted the **Convention on the Rights of the Child (CRC).** The CRC is the most widely and rapidly ratified human rights treaty in history. Only two member states—Somalia and the United States—have not ratified the agreement. Somalia is currently unable to ratify the convention in the absence of a recognized government. By signing the convention, the United States has signaled its intention to ratify, but has yet to do so. Twenty countries have included the convention in their constitutions, and another 32 have modified laws to comply with the CRC's terms.

1991. UNICEF sponsored the First International Conference on AIDS Orphans to increase awareness and reaffirm the importance of the rights of affected children and the principles set forth in the CRC.

1994. The Lusaka Declaration, adopted during the UNICEF/USAID-funded workshop in Zambia for 15 countries in East and Southern Africa on support to OVC, called for an assessment of the magnitude of the OVC problem in the region.

1997. USAID published *Children on the Brink: Strategies to Support HIV/*AIDS, which provided the first comprehensive global estimate of children orphaned by AIDS (defined as any child whose mother or father had died as a result of AIDS).

2001. The UNGASS on HIV/AIDS confirmed support for the MDG target of halting the epidemic by 2015 and creating a global trust fund. The UNGASS Declaration of Commitment specified HIV/AIDS targets, including national policies and strategies to be developed by 2003 and ideally implemented by 2005 to ensure a supportive environment for children affected by HIV and AIDS.

2002. UNAIDS, UNICEF, and USAID jointly released *Children on the Brink 2002,* which provided estimates of orphans, including children orphaned by AIDS, for 1990–2010 by region. The report noted that sub-Saharan Africa had the largest proportion of orphans due to AIDS. It also cited the several social, economic, and political effects of HIV on millions of vulnerable children, beyond orphans, but noted that data and studies on affected children were non-existent. The report recommended the following five program strategies to bolster national and local responses to the problem of children affected by HIV and AIDS:[13]

- Strengthening family capacity to care for affected children
- Supporting community-based responses
- Strengthening children's capacity to support themselves
- Ensuring that governments develop appropriate policies and essential services for the most vulnerable children
- Raising societal awareness for a broad, shared sense of responsibility and support to affected children

2003. Congress enacted and President George W. Bush signed the United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, authorizing funding for the President's Emergency

[12] See also Smart's (2003) chronology of key events from 1994 to 2002; the updated version in the 2004 *Framework* (UNAIDS, UNICEF, and Global Partners Forum, 2004), with particular reference to major events in Africa; and UNAIDS 2008 Epidemic Update.

[13] Subsequent international and national documents have re-emphasized the five strategies.

Plan for AIDS Relief (PEPFAR). The act authorized $15 billion over five years and included the following targets:

- Treatment for 2 million
- Prevention of 7 million new infections
- Care for 10 million, including OVC

2003. Considering slow progress toward achieving child-related goals of UNGASS, U.N. Secretary-General Kofi Annan addressed member states with generalized epidemics and urged them to develop and implement strategies to meet the needs of orphans and children affected by HIV.

2003. USAID, UNICEF, UNAIDS, and the World Food Program (WFP) collaborated on rapidly improving the quality of the response to orphans and children affected by HIV. Rapid assessment and action planning took place in 17 African countries selected for their high HIV prevalence, high number of orphans, and inclusion in PEPFAR programming (Phiri and Webb, 2004). National plans of action were to be developed as two-year emergency plans for 2004–2006, although several countries extended their plans' terms to five years or made efforts to link them closely with other government initiatives rather than as emergency responses (Engle, 2008).

2004. The Global Partners Forum (UNICEF et al., 2004) published *Framework for the Protection, Care, and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (referred to as the *Framework*). In November 2003, forum leaders convened stakeholders and experts from various sectors to develop the *Framework*. Endorsed by global leaders, the landmark document drew attention to the following three categories of children under age 18 affected by HIV and AIDS:

- Children living with HIV (3 million in 2004)
- Children who have lost one or both parents due to AIDS (14 million in 2004)
- Children made vulnerable by the impact of HIV and AIDS due to poverty, the need to care for sick parents, food insecurity, armed conflict, harmful child labor practices, and inadequate access to basic health and education services

The *Framework* reaffirmed global OVC goals and the CRC principles, including children's participation in decisions affecting them and the reference age (under 18 years old) and the five strategies first advanced by UNAIDS, UNICEF, and USAID in *Children on the Brink, 2002*.

2004. UNAIDS, UNICEF, and USAID published *Children on the Brink, 2004*, which provided the most up-to-date and comprehensive statistics on children orphaned by AIDS and other causes. While previous editions of *Children on the Brink* presented data for children under age 15, the 2004 edition provided estimates for children under age 18, bringing the statistics in line with the international CRC definition. Sub-Saharan African countries were again highlighted for the highest proportion of children orphaned due by AIDS, even exceeding 50 percent in countries in southern Africa, where adult HIV prevalence rates were 10 percent or higher (UNICEF, 2003). However, large numbers of orphans due to AIDS were also estimated for sub-Saharan countries where adult HIV prevalence rates were less than 5 percent. The report highlighted India and China because the two countries have the largest number of orphans due to all causes. The updated estimates also showed that adolescents make up the majority of orphans in all countries. Moreover, the report drew attention to the changing developmental needs of OVC as they progress from infancy to age 17, passing through a number of life-cycle stages with varied social, emotional, and physical needs.

2005. Congress enacted and President George W. Bush signed the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act. The law required the U.S. Government to devise a

comprehensive strategy for addressing the needs of the millions of OVC. USAID is the interagency coordinator of this call to action and—as directed by the legislation—houses the Special Advisor for Assistance to Orphans and Other Vulnerable Children.

2005. UNICEF launched the *Unite for Children, Unite against AIDS* campaign to protect and support children affected by HIV and AIDS. Among various points, the partnership's first report (UNAIDS, 2005) noted that, although poverty reduction strategy papers (PRSP) propose policy actions for children, HIV, and poverty, PRSPs do not provide budget allocations or specific targets to be achieved for affected children, thus failing to address the long-term impact of the epidemic on children and the need for a sustained response (World Bank and UNICEF, 2004). The campaign regularly releases global estimates, updates, and stock-taking on children affected by HIV and AIDS (most recently, *Children and AIDS: Fourth Stocktaking Report* 2009).

2006. The UN General Assembly adopted the Political Declaration on HIV/AIDS, which reiterated member states' commitment to address OVC as a priority; provide support and rehabilitation to OVC and their families, including women and the elderly in their role as caregivers; and promote policies and programs to support and protect OVCs.

2006. PEPFAR issued *Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partners*. Reaffirming the *Framework*, the U.S. Government document set forth guiding principles that included a multisectoral, community-based approach that preserves and supports families; children's meaningful participation in decisions affecting them; recognition of the different needs of boys and girls and an appropriate response based on developmental stages; and linking prevention, treatment, and care programs.

2006. The Joint Learning Initiative on Children and HIV/AIDS (JLICA)— an independent alliance of researchers, policymakers, implementers, activists, and PLHIV from different countries—was launched to provide evidence-based guidance on how the global HIV response can better respond to children by putting families at the center of policies and programming. JLICA's founding organizations included Association François-Xavier Bagnoud International; the Bernard van Leer Foundation; Center for Health and Human Rights, Harvard University; the Global Equity Initiative, Harvard University; the Human Sciences Research Council; and the United Nations Children's Fund.

2008. Congress enacted and President George W. Bush signed the Tom Lantos and Henry J. Hyde United States Global Leadership against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. The PEPFAR reauthorization retains the 10 percent earmark for OVC activities. PEPFAR targets specify support for the care of 12 million people, including 5 million OVC.

2008. UNAIDS released the *2008 Update on the Global AIDS Epidemic* (UNAIDS, 2008), which emphasized the epidemic's continued impact on households, particularly women and children. While most high prevalence countries reported strategies in place to support OVC, the report noted that few national programs reach more than a small minority of such children. Moreover, orphan-support initiatives in high-prevalence countries continue to confront a host of challenges, especially stigma, limited resources, and limited government support, all compounded by the global economic crisis.

2009. JLICA published *Home Truths: Facing the Facts on Children, AIDS and Poverty*, the results of its review of studies on children and HIV/AIDS. The report noted that, for more than 25 years, affected children remained peripheral to the global HIV response. Governments and partners continue to use an individual-based approach to target OVC (through food support or schooling assistance and even supporting institutionalization despite studies demonstrating adverse effects on institutionalized children) rather than a family-centered approach; the result is enormous unmet needs among vulnerable children

(Richter, 2008; Sherr, 2008). While many funding mechanisms now recommend family-focused models, large-scale implementation of such approaches has not occurred. To redress these gaps and address persistent problems, JLICA recommended the following for a country's response to vulnerable and affected children:

- Strong leadership at the national government level
- A long-term national response that combines universal access to HIV services with a social protection agenda that extends support to all children in need, not just to orphans, through extended families and community networks (see MEASURE 2009 for evidence demonstrating the value of family and community members)
- A country response that includes efforts to tackle poverty and gender inequality as the social and economic disempowerment of girls and women drives the spread of HIV
- The use of promising strategies to reach OVC, including home health visits by community workers; early childhood development;[14] income transfers linked to basic services for the poorest or most fragile families;[15] and family-centered services within a primary health care model that integrates nutrition, education, and social support
- Interventions involving community workers (from the health and other sectors) who are well-trained, supervised, and compensated

2009. The U.S. Government and partners released *The Third Annual Report to Congress on Public Law 109-95, the Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2005* (USG, 2009). The report describes U.S. Government assistance to OVC provided by seven U.S. Government agencies, including USAID funding ($1.86 billion in FY 2008) disbursed to implementing partners to assist vulnerable children and their families in 113 countries. The report noted that international donors including the United States are helping millions of children, but millions more are suffering from poor governance, conflict, disaster, disease, and poverty deepened by the global economic crisis. PL 109-95 priorities for 2009–2010 and beyond include the following:

- Improved monitoring and evaluation systems through the development of a methodology for identifying the most at-risk populations of children and the development of databases on target populations, common definitions of key terms, and the U.S. Government's response
- A compendium of OVC best practices
- Tools for understanding how U.S. Government resources are allocated in responding to the causes (e.g., extreme poverty) or consequences (e.g., child labor, trafficking, and disease) of vulnerability or paying for the direct costs of care and support versus policy dialogue and capacity building to build sustainable country programs
- Funding to implement PL 109-95

[14] See also Chandan and Richter (2008); Engle (2008); and Schenk (2009).
[15] Income transfers have been demonstrated to work even in poor countries such as Lesotho and Mozambique.

ANNEX 3. GFATM TERMS[16]

Affected communities. Communities of people living with or affected by AIDS, tuberculosis, or malaria.

Country Coordinating Mechanism (CCM). A country-level partnership that includes representatives of government, multilateral and bilateral development partners, nongovernmental and faith-based organizations, affected communities, academic institutions, and the private sector. The CCM develops and submits proposals to the Global Fund based on the country's needs. It nominates the PR. It is responsible for overseeing implementation of all programs in the country financed by Global Fund grants and for submitting grant renewal requests.

Disbursement. Periodic payment of grant funds to a Principal Recipient.

Grant (or grant agreement). A written agreement between the Global Fund and a PR that outlines the terms and conditions of Global Fund financing and the targets to be achieved. In most cases, the initial term lasts for two years (Phase 1), which can be extended for up to a further three years if the Global Fund Board decides to commit additional resources for Phase 2.

Grant consolidation. The process of creating a single legal grant agreement to cover all Global Fund financing to a given PR for a disease as opposed to separate agreements each time a new proposal for that disease is approved. Consolidation permits streamlined grant management of the implementation, reporting, and monitoring and evaluation work involved with more than one grant.

Local fund agent (LFA). A local, independent body contracted by the Global Fund to provide oversight of a PR on behalf of the Global Fund. Before the Global Fund signs a grant agreement, the LFA assesses the capacity of the nominated PR in the areas of financial management, programmatic management, monitoring and evaluation, and procurement and supply management. On an ongoing basis, it verifies the PR's periodic disbursement requests and progress updates and performs any other ad hoc monitoring activities.

Performance-based funding. The allocation of resources based on the demonstration of performance is at the heart of the Global Fund's model, with only those PRs demonstrating results from Global Fund monies already received eligible for additional funding after the initial disbursement. The amount of additional funding is typically commensurate with results achieved.

Phase 1. The first two years in the term of a grant agreement.

Phase 2. Toward the end of Phase 1 of a grant, the Secretariat performs an assessment called the Phase 2 review. Based on the recommendation of the Secretariat, the Board decides whether to commit additional resources and extend the grant agreement for up to an additional three years, which is called Phase 2.

Principal recipient (PR). The entity legally responsible for implementation and management of a grant, as set out in a grant agreement between the entity and the Global Fund. The PR is nominated by the CCM and works with the Global Fund Secretariat to develop the grant agreement that specifies the budget and program results to be achieved under the grant. The PR receives disbursements from the Global Fund and uses the funds to implement programmatic activities and/or passes the funds on to sub-recipients for their use to implement programmatic activities. The PR is responsible for monitoring the program and reporting on progress to both the CCM and the Global Fund. Over the term of the grant agreement, the PR

[16] Source: http://www.theglobalfund.org/documents/publications/other/Strategy/Glossary.pdf.

requests additional disbursements from the Global Fund based on demonstrated progress toward intended results.

Proposal. A written document that serves as the basis of an application for a Global Fund grant and specifies, among other items, the beneficiaries, objectives, and activities to be supported by the requested funding.

Recipients. Governments, NGOs, and others that receive funding from the Global Fund.

Rolling Continuation Channel (RCC). A new mechanism through which well-performing grants can seek continued funding at the end of Phase 2. The process is more streamlined and flexible than a normal application under a new proposal.

Rounds. The Global Fund solicits funding proposals on a periodic basis and reviews all of them simultaneously, a process referred to as a funding "round." The Global Fund Board has decided that "calls for proposals" should be issued at least annually.

Sub-recipient. An organization that receives Global Fund financing through a PR in order to carry out activities that are part of a grant agreement.

Technical Evaluation Reference Group (TERG). An advisory body providing independent assessment and advice to the Global Fund Board on monitoring and evaluation. The Board also directs the TERG to examine specific programmatic aspects of the Global Fund and to advise the Secretariat on evaluation approaches and practices, reporting procedures, and other technical and managerial aspects of monitoring and evaluation at all levels.

Technical Review Panel (TRP). An independent, impartial team of international experts in HIV/AIDS, tuberculosis, malaria, and general issues such as health systems appointed by the Global Fund Board. Its mandate is to review proposals submitted by CCMs, based on technical criteria, in a way that ensures integrity and consistency and to provide funding recommendations to the Board.

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